2010 – 2011
SOUTH CAROLINA HEALTH PLAN

South Carolina State Health Planning Committee
South Carolina Department of Health and Environmental Control

Effective November 12, 2010

SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

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CHAPTER I

INTRODUCTION

A. Legal Basis:

Section 44-7-180 of the South Carolina Code of Laws requires the Department of Health and Environmental Control, with the advice of the S.C. State Health Planning Committee, to prepare a State Health Plan for use in the administration of the Certificate of Need Program.

B. Purpose:

The South Carolina Health Plan outlines the need for medical facilities and services in the State. This document is used as one of the criteria for reviewing projects under the Certificate of Need Program.

C. Health Planning Committee:

This committee is composed of fourteen members. Twelve are appointed by the Governor with at least one member from each congressional district. Health care consumers, health care financiers, including business and insurance, and health care providers are equally represented. One member is appointed by the Chairman of the Board of Health and Environmental Control and the State Consumer Advocate is an ex-officio member. The State Health Planning Committee will review the South Carolina Health Plan and submit it to the Board of Health and Environmental Control for final revision and adoption.

D. Relationship With Other Agencies:

The Department has received consultation and advice from a number of State Agencies, including the Department of Mental Health, Department of Disabilities and Special Needs, Vocational Rehabilitation Department, Department of Social Services, Department of Alcohol and Other Drug Abuse Services, Continuum of Care for Emotionally Disturbed Children, and the Department of Health and Human Services, during the development of this plan including the collection and analysis of data. Other organizations affected under the program, such as the S.C. Hospital Association, the S.C. Home Care Association and the S.C. Health Care Association, have been consulted as the need arises. The Department wishes to express its appreciation for their assistance.

The Department is aware that the ultimate responsibility for administering this program cannot be shared with any individual or organization; however, it does recognize the valuable contributions that can be made by other interested organizations and individuals. For that reason it will be the policy to actively seek cooperation and guidance from anyone who wishes to comment on this plan.

E. Standards of Construction and Equipment:

Construction of health care facilities will comply with the Standards for Licensing as promulgated by the S.C. Department of Health and Environmental Control.

F. Standards for Maintenance and Operation:

Pursuant to the "State Certification of Need and Health Facility Licensure Act," the Division of Health Licensing within the Department of Health and Environmental Control (DHEC) is designated as the responsible agency for the administration and enforcement of basic standards for maintenance and operation of health care facilities and services in South Carolina.

G. State Certification of Need and Health Facility Licensure Act:

1. The purpose of the State Certification of Need and Health Facility Licensure Act, as amended, is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services that will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

2. This law requires the:

   (a) issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;

   (b) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;

   (c) preparation and publication of a State Health Plan, with the advice of the health planning committee; and

   (d) licensure of facilities rendering medical, nursing and other health care.

3. An applicant desiring a Certificate of Need for a health-related facility or service or any specific or general information pertaining to the law or its application may contact the Bureau of Health Facilities and Services Development, DHEC, at their mailing address: 2600 Bull Street, Columbia, South Carolina, 29201. The telephone number is (803) 545-4200; fax number is (803) 545-4579.

4. A copy of S.C. Department of Health and Environmental Control Regulation No. 61-15, Certification of Need for Health Facilities and Services, may be obtained from the above address, or accessed on the internet through www.scdhec.net.

H. Relative Importance of Project Review Criteria:

A general statement has been added to each section of Chapter II stating the project review criteria considered to be the most important in reviewing certificate of need applications for each type of facility, service, and equipment. These criteria are not listed in order of importance, but sequentially, as found in Chapter 8 of Regulation No. 61-15, Certification of Need for Health Facilities and Services. In addition, a finding has been made in each section as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse effects caused by the duplication of any existing facility, service or equipment.

I. Interpretation of the Plan:

The criteria and standards set forth in the Plan speak for themselves, and each section of the Plan must be read as a whole.

J. Quality of Patient Care:

There is both local and national interest regarding the quality of care in the delivery of health care services. The Department of Health and Environmental Control shares these concerns. Organizations such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the Leapfrog Group have focused attention upon both patient safety and outcomes. These include the reduction of medical errors, decreasing the risk of health care-acquired infections, and the following of best practices for patient care.

During the development of the current Plan, staff has reviewed the availability of data and quality standards for the types of beds and services referenced in the Plan. To the extent practicable, we have addressed quality standards in those sections of the Plan where we were comfortable that they were appropriate. However, we were not always able to identify standards that could be considered directly applicable for a bed or service in the Plan.

Therefore, where no standards are listed, an applicant may be requested to provide data from sources such as mySChospitals.com, hospitalcompare.hhs.gov, or leapfroggroup.org, to document how its quality of care compares to state, regional, or national averages.

K. Staffing Standards:

During the development of the 2008-09 South Carolina Health Plan, the Planning Committee was requested to undertake a study to determine how best to incorporate nursing and technical staffing information into future Plans. We agreed to undertake such a study; however, we do not have the manpower or technical expertise to conduct this research single-handedly. Staff is currently participating on the Steering Committee for the Office of Healthcare Workforce Research for Nursing (OHWRN), which has a four-year Duke Endowment grant to develop a supply/demand forecast model for nursing (as part of a larger effort that includes also includes allied technical staff).

Staff amended the 2009 Joint Annual Report (JAR) formats to obtain the baseline numbers for the current number and type of staff (RNs, EKG Techs, Physical Therapists, etc) by sector (hospitals, nursing homes, ASFs, etc). The research will also involve getting health care facilities to project their future needs for additional staff, through both currently budgeted vacancies and planned new projects. We will also have to determine what, if any, staffing guidelines or requirements exist for the various health professions. Only when we have this information available can we attempt to create standards tying staffing requirements to sections in the Plan. Therefore, at this point, we do not have reliable staffing requirements that would be appropriate as CON standards in the Plan.

More information on the OHWRN study can be found at:

http://sc.edu/nursing/workforce/workforce.html

CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

This State Plan has adopted four regions and one statewide category for the purpose of inventorying health facilities and services as specified in Section C. below. These regions, based on existing geographic, trade and political areas, are a practical method of administration.

The need for hospital beds is based on the utilization of individual facilities. Nursing home and home health service needs are projected by county. The need for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents is based on various service areas and utilization methodologies specified herein. Institutions serving a restricted population throughout the state are planned on a statewide basis. The need for most services (cardiac catheterization, open heart surgery, etc.) is based upon the service standard, which is a combination of utilization criteria and travel time requirements. Each service standard constitutes the service area for that particular service.

Any service area may cross multiple administrative, geographic, trade and/or political boundaries. Due to factors that may include availability, accessibility, personal or physician preferences, insurance and managed care contracts or coverage, or other reimbursement issues, patients may seek and receive treatment outside the county or inventory region in which they reside and/or outside of the state. Therefore, service areas may specifically cross inventory regions and/or state boundaries. The need for a service is analyzed by an assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan and applicable statutes and regulations.

B. Exceptions to Service Area Standards:

The health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, a number of health care facilities are consolidating and establishing provider networks in order to better compete for contracts within the new environment. This is particularly important for the smaller, more rural facilities that run the risk of being bypassed by insurers and health care purchasers looking for the availability of comprehensive health care services for their subscribers.

Given the changing nature of the health care delivery system, affiliated hospitals may sometimes want to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; however, such

transfers or exchanges could only occur between facilities within the same licensing category. A Certificate of Need would be required to achieve the transfer or exchange of services. In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

(1) A transfer or exchange of services may be approved only if there is no overall increase in the number or amount of such services;

(2) Although such transfers may cross county or service area lines, the facilities must be located within the one-way driving time established for the proposed service of each other, as determined by the Department;

(3) The facility receiving the service must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

(4) The applicants must explain the impact of transferring the technology on the health care delivery system of the county and/or service area from which it is to be taken; any negative impact must be detailed, along with the perceived benefits of the proposal;

(5) The facility giving up the service may not use the loss of such services as justification for a subsequent request for the approval of establishment of such service;

(6) A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of services must be included in the Certificate of Need process;

(7) Each facility giving up a service must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

Region	Counties
I	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, and Union.
II	Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda and York.
III	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter and Williamsburg.
IV	Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper and Orangeburg.

D. Estimated State Civilian Population:

Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,401,230 for 2009 and projected population of 4,719,530 for 2016. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2009 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was November 1, 2010.

CHAPTER III

ACUTE CARE HOSPITALS

A. General Hospitals:

1. Definitions:

"Hospital" means a facility organized and administered to provide overnight medical or surgical care or nursing care of illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy.

"Hospital bed" means a bed for an adult or child patient. Bassinets for the newborn in a maternity unit nursery, beds in labor rooms, recovery rooms, and other beds used exclusively for emergency purposes are not included in this definition.

2. Bed Capacity:

(a) For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds, even though temporarily not used for such purposes. The number of beds counted in any patient room is the maximum number for which adequate square footage is provided, except that single beds in single rooms have been counted even if the room contained inadequate square footage.

Adequate square footage is defined as:

100 square feet in single rooms;
80 square feet per bed or pediatric crib in multi-bed rooms;
40 square feet per bassinet in pediatric nurseries.

In measuring the square footage of patient rooms for the purpose of determining bed capacity, only the net usable space in the room was considered. Space in toilet rooms, washrooms, closets, vestibules, and corridors was not included.

(b) For facilities constructed under the Certificate of Need program, bed capacity will be as stated in the certificate, regardless of oversize room construction.

(c) For Areas Included:

1. Bed space in <u>all</u> nursing units, including: (1) intensive care unit and (2) minimal or self-care units.
2. Isolation units.

3. Pediatric units, including: (1) pediatric bassinets and (2) incubators located in the pediatric department.
4. Observation units equipped and staffed for overnight use.
5. All space designated for inpatient bed care, even if currently closed or assigned to easily convertible, non-patient uses such as administration offices or storage.
6. Space in areas originally designed as solaria, waiting rooms, offices, conference rooms and classrooms that have necessary fixed equipment and are accessible to a nurses station exclusively staffed for inpatient care.
7. Bed space under construction if planned for immediate completion (not an unfinished "shell" floor).

(d) For Areas Excluded:

1. Newborn nurseries in maternity department.
2. Labor rooms.
3. Recovery rooms.
4. Emergency units.
5. Preparation or anesthesia induction rooms.
6. Rooms used for diagnostic or treatment procedures unless originally designed for patient care.
7. Hospital staff bed areas, including accommodations for on-call staff unless originally designed for patient care.
8. Corridors.
9. Solaria, waiting rooms and other areas that not permanently set aside, equipped and staffed exclusively for inpatient bed care.
10. Unfinished space (shell) [an area that is finished except for movable equipment shall not be considered unfinished space].
11. Psychiatric, substance abuse and comprehensive rehabilitation units of general hospitals are separate categories of bed utilizing the same criteria outlined for general acute beds.

3. Inventory:

(a) All licensed general hospitals, including Federal facilities, are listed in the inventory. Patient days and admissions are as reported by the hospital. The number of patient days utilized for the general hospital bed need calculations does not include days of care rendered in licensed psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding inventories for each type of service. In addition, the days of care provided in Long-Term Care hospitals are not included in the general bed need calculations.

(b) Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation, such as:

1. Fire-resistivity of each building.
2. Fire and other safety factors of each building.
3. Design and structural factors affecting the function of nursing units.
4. Design and structural factors affecting the function of service departments.

4. Narrative: General Hospital Beds:

The General Acute Hospital bed need methodology uses the following variable occupancy rate factors:

0-174 bed hospitals, 65%;
175-349 bed hospitals, 70%; and
350+ bed hospitals, 75%.

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, recognizing that different population groups have different hospital utilization rates. For some hospitals, different age groups were used based on the data provided by the facility.

Where the term "hospital bed need" is used, these figures are based upon utilization data for the general acute hospitals. This term does not suggest that facilities cannot operate at higher occupancy rates than used in the calculations without adding additional beds.

The methodology for calculating bed need is as follows

(a) Calculations of bed need are made for individual hospitals, because of the differing occupancy factors used for individual facilities, and then summed by county to get the overall county bed need.

(b) 1. Multiply the current facility use rate by age cohort by the projected population by age cohort (in thousands) and divide by 365 to obtain a projected average daily census by age cohort.

2. Divide the sum of the age cohort projected facility average daily census by the variableoccupancy (.65/.70/.75) to determine the number of beds needed to meet the area's need.

(c) The number of additional beds needed or excess beds is obtained by subtracting the number of existing beds from the bed need.

(d) If a county indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the county indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site.

The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.

(e) If there is a need for additional hospital beds in the county, then any entity may apply to add these beds within the county, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the county. An applicant requesting additional beds beyond those indicated as needed by the methodology stated above, must document the need for additional beds based on historical and projected utilization, floor plan layouts, projected population growth that has not been considered in this Plan or other factors demonstrating the need for the proposed beds. It is up to the applicant to document the need and the potential negative impact on the existing facilities.

(f) No additional hospitals will be approved unless they are a general hospital and will provide:

1. A 24-hour emergency services department, and meet the requirements to be a Level III emergency service as defined in Regulation 61-16 Sec. 613 Emergency Services.

2. Inpatient medical services to both surgical and non-surgical patients, and

3. Medical and surgical services on a daily basis within at least 6 of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS), as follows:

   MDC 1: Diseases and disorders of the nervous system
   MDC 2: Diseases and disorders of the eye
   MDC 3: Diseases and disorders of the ear, nose, mouth and throat
   MDC 4: Diseases and disorders of the respiratory system
   MDC 5: Diseases and disorders of the circulatory system
   MDC 6: Diseases and disorders of the digestive system
   MDC 7: Diseases and disorders of the hepatobiliary system and pancreas
   MDC 8: Diseases and disorders of the musculoskeletal system and connective tissue
   MDC 9: Diseases and disorders of the skin, subcutaneous tissue and breast
   MDC 10: Endocrine, nutritional and metabolic diseases and disorders
   MDC 11: Diseases and disorders of the kidney and urinary tract
   MDC 12: Diseases and disorders of the male reproductive system
   MDC 13: Diseases and disorders of the female reproductive system
   MDC 14: Pregnancy, childbirth and the puerperium
   MDC 15: Newborns/other neonates with conditions originating in the prenatal period
   MDC 16: Diseases and disorders of the blood and blood-forming organs and immunological disorders

MDC 17: Myeloproliferative diseases and disorders and poorly differentiated neoplasms
MDC 18: Infectious and parasitic diseases
MDC 19: Mental diseases and disorders
MDC20: Alcohol/drug use and alcohol/drug-induced organic mental disorders
MDC 21: Injury, poisoning and toxic effects of drugs
MDC 22: Burns
MDC 23: Factors influencing health status and other contact with health services
MDC 24: Multiple significant traumas
MDC 25: Human immunodeficiency virus infections

Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients and that un-reimbursed services for indigent and charity patients are provided at a percentage which meets or exceeds other hospitals in the service area.

(g) In some areas of South Carolina, a considerable influx of tourists is not counted in the permanent population. If an individual hospital in these areas can document and demonstrate the need for additional beds due to non-resident (tourist) population and seasonal utilization fluctuations due to this population, then, based on further analysis, the Department may approve some additional beds at the existing hospital.

(h) Should a hospital request additional beds due to the deletion of services at a Federal facility that results in the immediate impact on the utilization of the hospital, then additional beds may be approved at the affected hospital. The impacted hospital must document this increase in demand and explain why additional beds are needed to accommodate the care of patients previously served at a Federal facility. Based on the analysis of utilization provided by the affected hospital, the Department may approve some additional hospital beds to accommodate this immediate need.

(i) Due to the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric, rehabilitation and/or substance abuse beds to general acute care hospital beds, the following policies may apply:

1. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert these nursing home beds to acute care hospital beds only within the hospital provided the hospital can document an actual need for these additional acute care beds. Need will be based on actual utilization, using current information. A CON is required for this conversion.

2. Existing general hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert these specialty beds to acute care hospital beds, regardless of the projected need for general acute care hospital beds, provided a Certificate of Need is received.

(j) Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. A proposal to transfer or exchange hospital beds requires a Certificate of Need and must comply with the following criteria:

1. A transfer or exchange of beds may be approved only if there is no overall increase in the number of beds;

2. Such transfers may cross county lines; however, the applicants must document with patient origin data the historical utilization of the receiving facility by residents of the county giving up beds;

3. Should the response to Criterion 2 fail to show a historical precedence of residents of the county transferring the beds utilizing the receiving facility, the applicants must document why it is in the best interest of these residents to transfer the beds to a facility with no historical affinity for them;

4. The applicants must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impact must be detailed, along with the perceived benefits of such an agreement;

5. The facility receiving the beds must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

6. The facility giving up the beds may not use the loss of these beds as justification for a subsequent request for the approval of additional beds;

7. A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of beds must be included in the Certificate of Need application;

8. Each facility giving up beds must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

(k) Factors to be considered regarding modernization of facilities should include:

1. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
2. The ability to update medical technology within the existing plant.
3. Existence of The Joint Commission (TJC) deficiencies or "grandfathered" licensure deficiencies.
4. Cost efficiency of the existing physical plant versus plant revision, etc.
5. Private rooms are now considered the industry standard.

(l) Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on health delivery and status within the service area.

The following pages depict the calculation of hospital bed need as described earlier.

Quality

A number of quality indicators have been identified for hospitals by organizations such as CMS (Hospital Compare), the Agency for Healthcare Research and Quality (AHRQ), and the Commonwealth Fund (Why Not the Best?). Data for these measures are accessible on-line, and it is possible to compare how hospitals rate on these various measures. They can also be compared against similar facilities (i.e. teaching hospitals) and against state and/or national averages.

Unfortunately, because each organization categorizes its data differently, these indicators can only be discussed in generalities. They can be roughly divided into four categories. The first measurements are what CMS calls Hospital Process of Care measures. These capture how often hospitals perform the recommended processes for different diagnoses. For example, do the hospitals give heart attack patients aspirin when they arrive at the hospital and smoking cessation advice/counseling before they're discharged? Are surgical patients receiving the right antibiotics prior to surgery to prevent infections or the right treatment to prevent blood clots? Source: http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

The second type of indicators are what AHRQ calls Patient Safety Indicators (PSIs). These are indicators on potential preventable in-hospital adverse events and complications following surgery, childbirth, and other procedures. They include anesthesia complications, decubitus ulcers, leaving foreign bodies in after surgery, post-operative infections, transfusion reactions, and birth trauma. Source: http://www.qualityindicators.ahrq.gov/downloads/psi/2006-Feb-PatientSafetyIndicators.pdf

A sub-set of patient safety indicators is DHEC's Hospital Acquired Infections (HAI) report. It lists the actual and expected rates of Surgical Site Infections (SSIs) for various types of surgeries (coronary bypass, gallbladder removal, hysterectomy, knee replacement, etc.) and Central Line Associated Blood Stream Infection (CLABSI) rates for hospitals. Source: http://www.scdhec.gov/health/disease/hai/reports.htm

Next are Inpatient Quality Indicators (IQIs). These include volume (where there has been a link determined between the number of procedures performed and an outcome such as mortality), in-house mortality (examines outcomes following procedures and for common medical conditions), and utilization (where questions have been raised about over-use or under-use of a procedure). Examples include in-house mortality from hip replacements, GI hemorrhages, strokes, and pneumonia, and the volume of open heart surgeries and cesarean sections performed. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

The final indicator is Patient Satisfaction. A patient's perceptions of the care received during a hospital stay impacts how the patient views the outcome of the stay. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey was developed by CMS and AHRQ to collect patient feedback. It asks whether nurses were readily available when called, procedures were adequately explained before they were performed, the room was kept clean, it was quiet at night, etc. As part of these surveys, patients rate their overall satisfaction with the facility (0-10) and whether they would recommend the hospital to others. Perceptions of poor patient care can hurt a hospital, even if the outcomes were satisfactory. Source: http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

Starting in June 2010, Hospital Compare will report outpatient quality measures related to heart attack and chest pain treatment, outpatient surgery safety, and imaging equipment efficiency. Hospitals that don't comply with the quality data reporting requirements face a 2% reduction in their reimbursements. Source: http://www.cms.hhs.gov/HospitalQualityInits/34_HospitalOutpatientMeasures.asp

Hospitals should have high compliance rates for the procedures that have been identified as improving the quality of care or reducing the risks of complications. Infection rates should be below or comparable to the expected numbers.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Cost Containment; and
g. Adverse Effects on Other Facilities.

General hospital beds are located within approximately thirty (30) minutes travel time for the majority of the residents of the State, and current utilization and population growth are factored into the methodology for determining general hospital beds. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANMED HEALTH MEDICAL CENTER	<18	42,730	43,810	715	2				
	18-64	110,580	116,170	40,514	117				
	+65	25,330	30,090	34,666	113				
	TOTAL	178,640	190,070	75,895	231	0.75	309	423	-114
ANMED WOMEN'S & CHILDRENS HOSPITAL	<18	42,730	43,810	75	0				
	18-64	110,580	116,170	4,376	13				
	+65	25,330	30,090	3,564	12				
	TOTAL	178,640	190,070	8,015	24	0.65	38	72	-34
ANDERSON COUNTY TOTAL							**347**	**495**	**-148**
UPSTATE CAROLINA MEDICAL CENTER	<18	14,660	15,330	714	2				
	18-64	35,590	37,960	8,081	24				
	+65	6,980	8,270	8,621	28				
	TOTAL	57,230	61,560	17,417	54	0.65	83	125	-42
CHEROKEE COUNTY TOTAL							**83**	**125**	**-42**
GREENVILLE MEMORIAL MEDICAL CENTER	<18	99,330	102,030	19,155	54				
	18-64	268,100	288,490	108,811	321				
	+65	49,040	59,040	42,583	140				
	TOTAL	416,470	449,560	170,549	515	0.75	687	746	-59
GREER MEMORIAL HOSPITAL	<18	99,330	102,030	264	1				
	18-64	268,100	288,490	8,734	26				
	+65	49,040	59,040	4,853	16				
	TOTAL	416,470	449,560	13,851	42	0.65	65	82	-17
HILLCREST MEMORIAL HOSPITAL	<18	99,330	102,030	8	0				
	18-64	268,100	288,490	3,113	9				
	+65	49,040	59,040	3,432	11				
	TOTAL	416,470	449,560	6,553	21	0.65	32	43	-11
PATEWOOD MEMORIAL HOSPITAL	<18	99,330	102,030	86	0				
	18-64	268,100	288,490	1,629	5				
	+65	49,040	59,040	1,210	4				
	TOTAL	416,470	449,560	2,925	9	0.65	14	72	-58
SAINT FRANCIS - DOWNTOWN & SAINT	<18	99,330	102,030	365	1				
FRANCIS MILLENNIUM *1*	18-64	268,100	288,490	26,046	77				
	+65	49,040	59,040	32,503	107				
	TOTAL	416,470	449,560	58,914	185	0.70	264	276	-12
SAINT FRANCIS - EASTSIDE	<18	99,330	102,030	184	1				
	18-64	268,100	288,490	13,148	39				
	+65	49,040	59,040	4,707	16				
	TOTAL	416,470	449,560	18,039	55	0.65	84	93	-9
GREENVILLE COUNTY TOTAL							**1,146**	**1,312**	**-166**

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
OCONEE MEMORIAL HOSPITAL	<18	15,850	16,190	573	2				
	18-64	44,670	46,970	16,234	47				
	+65	14,070	17,810	11,205	39				
	TOTAL	74,590	80,970	28,012	87	0.65	134	169	-35
OCONEE COUNTY TOTAL							**134**	**169**	**-35**
CANNON MEMORIAL HOSPITAL	<18	29,100	30,670	15	0				
	18-64	81,770	88,280	1,528	5				
	+65	14,610	17,850	2,092	7				
	TOTAL	125,480	136,800	3,635	12	0.65	18	55	-37
PALMETTO BAPTIST MED CTR EASLEY	<18	29,100	30,670	277	1				
	18-64	81,770	88,280	8,392	25				
	+65	14,610	17,850	9,947	33				
	TOTAL	125,480	136,800	18,616	59	0.65	91	109	-18
PICKENS COUNTY TOTAL							**109**	**164**	**-55**
MARY BLACK MEMORIAL	<18	67,250	68,450	1,214	3				
	18-64	175,870	185,770	18,897	55				
,	+65	34,870	42,220	6,823	23				
	TOTAL	277,990	296,440	26,934	81	0.70	115	176	-61
SPARTANBURG REG MED CTR & 2 VILLAGE HEALTH CENTRE	<18	67,250	68,450	3,414	10				
	18-64	175,870	185,770	71,007	205				
	+65	34,870	42,220	65,502	217				
	TOTAL	277,990	296,440	139,923	432	0.75	576	532	44
SPARTANBURG COUNTY TOTAL							**691**	**708**	**-17**
WALLACE THOMSON HOSPITAL	<18	7,040	6,890	284	1				
	18-64	17,540	16,780	4,222	11				
	+65	4,980	5,520	4,960	15				
	TOTAL	29,560	29,190	9,466	27	0.65	41	143	-102
UNION COUNTY TOTAL							**41**	**143**	**-102**
REGION II									
ABBEVILLE AREA MEDICAL CENTER	<18	6,760	6,850	70	0				
	18-64	16,590	17,020	923	3				
	+65	4,120	4,740	1,564	5				
	TOTAL	27,470	28,610	2,557	8	0.65	12	25	-13
ABBEVILLE COUNTY TOTAL							**12**	**25**	**-13**

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHESTER REGIONAL MEDICAL CENTER	<18	8,940	9,050	413	1				
	18-64	21,680	21,970	3,127	9				
	+65	4,690	5,530	3,443	11				
	TOTAL	35,310	36,550	6,983	21	0.65	32	82	-50
CHESTER COUNTY TOTAL							**32**	**82**	**-50**
EDGEFIELD COUNTY HOSPITAL	<18	5,840	5,880	21	0				
	18-64	18,050	19,570	388	1				
	+65	3,130	4,290	1,339	5				
	TOTAL	27,020	29,740	1,748	6	0.65	10	25	-15
EDGEFIELD COUNTY TOTAL							**10**	**25**	**-15**
FAIRFIELD MEMORIAL HOSPITAL	<18	6,180	6,170	44	0				
	18-64	15,440	15,510	1,400	4				
	+65	3,250	4,220	1,472	5				
	TOTAL	24,870	25,900	2,916	9	0.65	14	25	-11
FAIRFIELD COUNTY TOTAL							**14**	**25**	**-11**
SELF REGIONAL HEALTHCARE	<18	17,830	18,260	1,586	4				
	18-64	43,290	44,970	25,638	73				
	+65	9,530	10,990	25,875	82				
	TOTAL	70,650	74,220	53,099	159	0.75	212	354	-142
GREENWOOD COUNTY TOTAL							**212**	**354**	**-142**
KERSHAW HEALTH	<18	14,120	14,690	1,069	3				
	18-64	36,290	38,920	11,304	33				
	+65	7,770	9,570	14,351	48				
	TOTAL	58,180	63,180	26,724	85	0.65	130	121	9
KERSHAW COUNTY TOTAL							**130**	**121**	**9**
SPRINGS MEMORIAL HOSPITAL	<18	15,490	15,470	1,088	3				
	18-64	40,240	41,430	13,804	39				
	+65	7,860	9,470	17,267	57				
	TOTAL	63,590	66,370	32,159	99	0.70	141	217	-76
LANCASTER COUNTY TOTAL							**141**	**217**	**-76**
LAURENS COUNTY HOSPITAL	<18	17,710	17,750	234	1				
	18-64	48,110	51,780	5,549	16				
	+65	10,530	12,950	6,194	21				
	TOTAL	76,350	82,480	11,977	38	0.65	58	76	-18
LAURENS COUNTY TOTAL							**58**	**76**	**-18**

2016 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
LEXINGTON MEDICAL CENTER		<18	42,173	43,661	1,067	3				
		18-64	114,487	124,908	49,370	148				
		+65	19,789	25,701	39,550	141				
		TOTAL	176,449	194,270	89,987	291	0.75	388	414	-26
LEXINGTON COUNTY TOTAL								**388**	**414**	**-26**
NEWBERRY COUNTY MEMORIAL		<18	8,980	9,120	304	1				
		18-64	23,610	24,040	3,637	10				
		+65	5,700	6,920	6,074	20				
		TOTAL	38,290	40,080	10,015	31	0.65	48	90	-42
NEWBERRY COUNTY TOTAL								**48**	**90**	**-42**
PALMETTO HEALTH BAPTIST & PALMETTO HEALTH PARKRIDGE	*3*	<18	100,167	103,129	936	3				
		18-64	271,993	285,622	52,218	150				
		+65	42,961	55,229	17,550	62				
		TOTAL	415,121	443,980	70,704	215	0.75	286	363	-77
PALMETTO HEALTH RICHLAND		<18	100,167	103,129	24,804	70				
		18-64	271,993	285,622	98,010	282				
		+65	42,961	55,229	42,248	149				
		TOTAL	415,121	443,980	165,062	501	0.75	668	579	89
PROVIDENCE HOSPITAL		<18	100,167	103,129	55	0				
		18-64	271,993	285,622	21,915	63				
		+65	42,961	55,229	30,184	106				
		TOTAL	415,121	443,980	52,154	170	0.70	242	258	-16
PROVIDENCE HOSPITAL NORTHEAST		<18	100,167	103,129	88	0				
		18-64	271,993	285,622	6,401	18				
		+65	42,961	55,229	3,806	13				
		TOTAL	415,121	443,980	10,295	32	0.65	49	84	-35
RICHLAND COUNTY TOTAL								**1,245**	**1,284**	**-39**
PIEDMONT MEDICAL CENTER		<18	45,710	46,810	1,363	4				
		18-64	123,240	137,260	29,411	90				
		+65	20,400	26,020	25,064	88				
		TOTAL	189,350	210,090	55,838	181	0.70	259	268	-9
YORK COUNTY TOTAL								**259**	**268**	**-9**
REGION III										
CHESTERFIELD GENERAL HOSPITAL		<18	11,120	11,130	559	2				
		18-64	27,410	27,860	4,899	14				
		+65	5,520	6,790	4,841	16				
		TOTAL	44,050	45,780	10,299	30	0.65	46	59	-13
CHESTERFIELD COUNTY TOTAL								**46**	**59**	**-13**

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CLARENDON MEMORIAL HOSPITAL	<18	7,800	7,750	378	1				
	18-64	20,540	20,410	7,356	20				
	+65	6,000	8,110	5,764	21				
	TOTAL	34,340	36,270	13,498	42	0.65	65	56	9
CLARENDON COUNTY							**65**	**56**	**9**
CAROLINA PINES REGIONAL	<18	17,630	17,140	1,915	5				
	18-64	42,550	42,800	17,266	48				
	+65	8,840	10,980	10,876	37				
	TOTAL	69,020	70,920	30,057	90	0.65	138	116	22
MCLEOD MEDICAL CENTER - DARLINGTON	<18	17,630	17,140		0				
	18-64	42,550	42,800	687	2				
	+65	8,840	10,980	1,517	5				
	TOTAL	69,020	70,920	2,204	7	0.65	11	49	-38
DARLINGTON COUNTY TOTAL							**149**	**165**	**-16**
MCLEOD MEDICAL CENTER - DILLON	<18	8,150	7,810	621	2				
	18-64	18,610	18,340	5,844	16				
	+65	3,540	4,160	4,155	13				
	TOTAL	30,300	30,310	10,620	31	0.65	47	79	-32
DILLON COUNTY TOTAL							**47**	**79**	**-32**
CAROLINAS HOSPITAL SYSTEM	<18	32,670	32,950	1,646	5				
	18-64	84,320	85,860	34,070	95				
	+65	16,670	20,960	24,820	85				
	TOTAL	133,660	139,770	60,536	185	0.70	264	310	-46
WOMENS CTR CAROLINAS HOSP SYSTEM	<18	32,670	32,950	161	0				
	18-64	84,320	85,860	3,322	9				
	+65	16,670	20,960	0	0				
	TOTAL	133,660	139,770	3,483	10	0.65	15	20	-5
LAKE CITY COMMUNITY HOSPITAL	<18	32,670	32,950	117	0				
	18-64	84,320	85,860	2,244	6				
	+65	16,670	20,960	1,963	7				
	TOTAL	133,660	139,770	4,323	12	0.65	19	48	-29
MCLEOD REGIONAL MEDICAL CENTER	<18	32,670	32,950	7,424	21				
	18-64	84,320	85,860	58,392	163				
	+65	16,670	20,960	47,365	163				
	TOTAL	133,660	139,770	113,181	347	0.75	462	453	9
FLORENCE COUNTY TOTAL							**760**	**831**	**-71**
GEORGETOWN MEMORIAL HOSPITAL	<18	12,790	12,180	786	2				
	18-64	36,480	37,310	8,725	24				
	+65	11,870	16,420	17,978	68				
	TOTAL	61,140	65,910	27,489	95	0.65	146	131	15

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
WACCAMAW COMMUNITY HOSPITAL	<18	12,790	12,180	389	1				
	18-64	36,480	37,310	8,187	23				
	+65	11,870	16,420	19,396	74				
	TOTAL	61,140	65,910	27,972	97	0.65	150	124	26
GEORGETOWN COUNTY TOTAL							**296**	**255**	**41**
CONWAY HOSPITAL	<18	43,410	44,190	1,165	3				
	18-64	149,460	166,970	19,194	59				
	+65	41,530	55,650	15,411	57				
	TOTAL	234,400	266,810	35,770	119	0.70	170	210	-40
GRAND STRAND REGIONAL MEDICAL CTR	<18	43,410	44,190	954	3				
	18-64	149,460	166,970	24,122	74				
	+65	41,530	55,650	32,517	119				
	TOTAL	234,400	266,810	57,593	196	0.70	280	269	11
LORIS COMMUNITY HOSPITAL & SEACOAST MEDICAL CENTER 4	<18	43,410	44,190	616	2				
	18-64	149,460	166,970	7,795	24				
	+65	41,530	55,650	8,054	30				
	TOTAL	234,400	266,810	16,465	55	0.65	85	155	-70
HORRY COUNTY TOTAL							**535**	**634**	**-99**
MARION REGIONAL HOSPITAL	<18	9,260	8,920	722	2				
	18-64	22,510	22,410	10,894	30				
	+65	4,510	5,570	6,037	20				
	TOTAL	36,280	36,900	17,653	52	0.65	80	124	-44
MARION COUNTY TOTAL							**80**	**124**	**-44**
MARLBORO PARK HOSPITAL	<18	7,150	6,880	236	1				
	18-64	17,150	16,030	2,330	6				
	+65	3,300	3,820	1,657	5				
	TOTAL	27,600	26,730	4,223	12	0.65	18	94	-76
MARLBORO COUNTY TOTAL							**18**	**94**	**-76**
TUOMEY	<18	30,990	31,900	3,803	11				
	18-64	69,940	71,540	37,497	105				
	+65	14,380	17,510	25,420	85				
	TOTAL	115,310	120,950	66,720	201	0.70	287	283	4
SUMTER COUNTY TOTAL							**287**	**283**	**4**
WILLIAMSBURG REGIONAL HOSPITAL	<18	9,560	8,950	11	0				
	18-64	22,090	21,130	661	2				
	+65	5,210	6,590	821	3				
	TOTAL	36,860	36,670	1,493	5	0.65	7	25	-18
WILLIAMSBURG COUNTY TOTAL							**7**	**25**	**-18**

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION IV									
AIKEN REGIONAL MEDICAL CENTER	<18	37,760	38,170	447	1				
	18-64	101,650	109,680	19,351	57				
	+65	22,550	28,170	20,479	70				
	TOTAL	161,960	176,020	40,277	129	0.70	184	183	1
AIKEN COUNTY TOTAL							**184**	**183**	**1**
ALLENDALE COUNTY HOSPITAL	<18	3,030	3,030	21	0				
	18-64	7,200	6,910	380	1				
	+65	1,720	2,180	836	3				
	TOTAL	11,950	12,120	1,237	4	0.65	6	25	-19
ALLENDALE COUNTY TOTAL							**6**	**25**	**-19**
BAMBERG COUNTY MEMORIAL HOSPITAL	<18	3,890	3,600	24	0				
	18-64	9,640	8,890	623	2				
	+65	2,280	2,760	2,407	8				
	TOTAL	15,810	15,250	3,054	10	0.65	15	59	-44
BAMBERG COUNTY TOTAL							**15**	**59**	**-44**
BARNWELL COUNTY HOSPITAL	<18	6,150	5,980	101	0				
	18-64	15,650	16,340	1,083	3				
	+65	3,410	4,330	1,208	4				
	TOTAL	25,210	26,650	2,392	8	0.65	12	53	-41
BARNWELL COUNTY TOTAL							**12**	**53**	**-41**
BEAUFORT MEMORIAL HOSPITAL	<18	27,880	26,630	1,414	4				
	18-64	86,160	93,740	19,600	58				
	+65	29,700	42,450	19,398	76				
	TOTAL	143,740	162,820	40,412	138	0.65	213	169	44
HILTON HEAD HOSPITAL	<18	27,880	26,630	213	1				
	18-64	86,160	93,740	7,036	21				
	+65	29,700	42,450	11,815	46				
	TOTAL	143,740	162,820	19,064	68	0.65	104	93	11
BEAUFORT COUNTY TOTAL							**317**	**262**	**55**
TRIDENT MED CENTER & BERKELEY MEDICAL CENTER *5*	<18	143,280	147,880	1,428	4				
	18-64	386,830	395,280	36,691	103				
	+65	75,760	102,240	32,998	122				
	TOTAL	605,870	645,400	71,117	229	0.70	327	346	-19
SUMMERVILLE MEDICAL CENTER	<18	143,280	147,880	417	1				
	18-64	386,830	395,280	10,725	30				
	+65	75,760	102,240	9,645	36				
	TOTAL	605,870	645,400	20,787	67	0.65	103	94	9

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
MUSC MEDICAL CENTER	<18	143,280	147,880	26,116	74				
	18-64	386,830	395,280	85,832	240				
	+65	75,760	102,240	34,413	127				
	TOTAL	605,870	645,400	146,361	441	0.75	589	604	-15
ROPER, ROPER ST FRANCIS MT PLEASANT	<18	143,280	147,880	81	0				
& ROPER ST FRANCIS - BERKELEY *6*	18-64	386,830	395,280	33,325	93				
	+65	75,760	102,240	46,987	174				
	TOTAL	605,870	645,400	80,393	267	0.75	356	401	-45
BON SECOURS ST FRANCIS XAVIER	<18	143,280	147,880	317	1				
	18-64	386,830	395,280	20,814	58				
	+65	75,760	102,240	14,245	53				
	TOTAL	605,870	645,400	35,376	112	0.70	160	204	-44
EAST COOPER REGIONAL MEDICAL CTR	<18	143,280	147,880	102	0				
	18-64	386,830	395,280	11,028	31				
	+65	75,760	102,240	5,836	22				
	TOTAL	605,870	645,400	16,966	53	0.65	81	140	-59
BERKELEY/CHARLESTON/DORCHESTER TOTAL							**1,616**	**1,789**	**-173**
COLLETON MEDICAL CENTER	<18	10,690	10,970	503	1				
	18-64	25,010	25,630	11,009	31				
	+65	5,590	6,990	11,329	39				
	TOTAL	41,290	43,590	22,841	71	0.65	110	131	-21
COLLETON COUNTY TOTAL							**110**	**131**	**-21**
HAMPTON REGIONAL MEDICAL CTR	<18	5,520	5,500	37	0				
	18-64	14,050	14,470	1,576	4				
	+65	2,950	3,790	2,109	7				
	TOTAL	22,520	23,760	3,722	12	0.65	18	32	-14
HAMPTON COUNTY TOTAL							**18**	**32**	**-14**
COASTAL CAROLINA MEDICAL CENTER	<18	5,090	4,890	27	0				
	18-64	14,820	16,450	1,603	5				
	+65	2,770	3,610	2,169	8				
	TOTAL	22,680	24,950	3,799	13	0.65	20	31	-11
JASPER COUNTY TOTAL							**20**	**31**	**-11**
REG MED CTR ORANGEBURG-CALHOUN	<18	23,760	23,840	2,079	6				
	18-64	58,790	59,200	24,788	68				
	+65	13,800	17,000	25,016	84				
	TOTAL	96,350	100,040	51,883	159	0.70	227	247	-20
ORANGEBURG/CALHOUN COUNTY TOTAL							**227**	**247**	**-20**

2016 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)

1 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BED NEED FROM THE EXISTING HOSPITAL 6/12/09.
2 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 9/9/05.
3 BED NEEDS COMBINED; NEW HOSPITAL CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED, CON ISSUED 6/8/10.
4 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED; CON 9/4/07.
5 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BED NEED FROM THE EXISTING HOSPITAL; APPEALED.
6 BED NEEDS COMBINED; MT PLEASANT WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 5/31/06. BERKELEY WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.

HOSPITAL OCCUPANCY RATES

	2007	2008	2009
REGION I	**56.8**	**55.8**	**53.5**
ANMED HEALTH MEDICAL CENTER	50.9	50.4	49.2
ANMED HEALTH WOMEN'S & CHILDREN'S	32.8	33.7	30.5
UPSTATE CAROLINA MEDICAL CENTER	37.3	33.9	38.2
GREENVILLE MEMORIAL MEDICAL CTR	69.8	66.8	62.6
GREER MEMORIAL	60.4	48.1	55.1
HILLCREST MEMORIAL HOSPITAL	55.0	50.6	41.8
PATEWOOD MEMORIAL	6.7	10.7	11.1
SAINT FRANCIS - DOWNTOWN	71.9	77.7	71.4
SAINT FRANCIS - EASTSIDE	50.2	56.5	53.1
SAINT FRANCIS - MILLENNIUM	---	---	---
OCONEE MEMORIAL HOSPITAL	52.3	44.8	48.0
CANNON MEMORIAL HOSPITAL	21.7	18.7	18.1
BAPTIST MED CTR EASLEY	47.6	51.4	46.8
MARY BLACK MEMORIAL HOSPITAL	46.5	44.3	41.9
SPARTANBURG REGIONAL MEDICAL CTR	68.3	72.4	71.8
VILLAGE HEALTHCARE CENTRE	---	---	18.0
WALLACE THOMSON HOSPITAL	20.8	21.1	18.1

	2007	2008	2009
REGION II	**60.3**	**58.4**	**57.4**
ABBEVILLE AREA MEDICAL CENTER	35.1	36.3	28.0
CHESTER REGIONAL MEDICAL CENTER	24.5	24.4	23.3
EDGEFIELD COUNTY HOSPITAL	23.6	21.6	19.2
FAIRFIELD MEMORIAL HOSPITAL	27.6	34.5	32.0
SELF REGIONAL HEALTHCARE	45.6	43.2	42.8
KERSHAW HEALTH	57.7	61.8	60.5
SPRINGS MEMORIAL HOSPITAL	50.6	50.3	52.4
LAURENS COUNTY HOSPITAL	44.7	44.7	43.2
LEXINGTON MEDICAL CENTER	75.8	73.9	68.2
NEWBERRY COUNTY MEM HOSPITAL	32.2	32.7	30.5
PALMETTO HEALTH BAPTIST	58.6	51.8	53.4
PALMETTO HEALTH RICHLAND	74.7	75.4	78.1
PROVIDENCE HOSPITAL	64.6	58.6	55.4
PROVIDENCE HOSPITAL NORTHEAST	74.0	60.9	61.3
PIEDMONT MEDICAL CENTER	64.9	62.6	57.1

	2007	2008	2009
REGION III	**61.8**	**59.9**	**57.0**
CHESTERFIELD GENERAL HOSPITAL	46.9	52.3	47.8
CLARENDON MEMORIAL HOSPITAL	71.1	68.4	66.0
CAROLINA PINES REGIONAL MED CTR	80.9	72.7	71.0
MCLEOD MED CTR - DARLINGTON	23.6	49.4	12.3
MCLEOD MED CTR - DILLON	41.4	39.2	36.8
CAROLINAS HOSPITAL SYSTEM	61.6	61.5	53.5
LAKE CITY COMMUNITY HOSPITAL	29.9	22.8	24.7
MCLEOD REGIONAL MEDICAL CENTER	73.8	71.4	68.5
WOMEN'S CENTER CAROLINAS HOSP	38.4	49.6	47.7
GEORGETOWN MEMORIAL HOSPITAL	61.7	55.4	57.3
WACCAMAW COMMUNITY HOSPITAL	83.7	81.5	87.4
CONWAY HOSPITAL	65.0	63.9	61.3
GRAND STRAND REGIONAL MED CTR	71.6	72.7	72.0
LORIS COMMUNITY HOSPITAL	44.2	39.3	43.0
MARION REGIONAL HOSPITAL	48.6	42.1	39.0
MARLBORO PARK HOSPITAL	17.2	15.4	12.3
TUOMEY	72.4	66.7	64.6
WILLIAMSBURG REGIONAL HOSPITAL	25.4	15.5	16.4

	2007	2008	2009
REGION IV	**59.4**	**57.1**	**56.7**
AIKEN REGIONAL MEDICAL CENTER	63.1	61.9	60.3
ALLENDALE COUNTY HOSPITAL	12.9	14.5	13.6
BAMBERG COUNTY MEMORIAL HOSP	26.4	9.7	14.2
BARNWELL COUNTY HOSPITAL	18.1	18.9	12.4
BEAUFORT MEMORIAL HOSPITAL	65.0	63.9	65.5
HILTON HEAD REGIONAL MEDICAL CTR	55.1	54.9	56.2
SUMMERVILLE MEDICAL CENTER	66.9	60.8	60.6
BON SECOURS ST FRANCIS XAVIER	71.3	50.4	47.5
CHARLESTON MEMORIAL HOSPITAL	18.5	26.8	---
EAST COOPER MEDICAL CENTER	49.1	49.3	46.5
MUSC MEDICAL CENTER	80.0	75.7	68.7
ROPER HOSPITAL	57.2	56.4	54.9
ROPER MOUNT PLEASANT HOSPITAL	---	---	---
TRIDENT MEDICAL CENTER	76.2	68.5	65.8
COLLETON MEDICAL CENTER	49.0	46.5	47.8
HAMPTON REGIONAL MEDICAL CENTER	12.6	12.3	31.9
COASTAL CAROLINA MEDICAL CENTER	45.7	33.6	33.6

B. Long-Term Acute Care Hospitals:

Long Term Acute Care Hospitals (LTACHs) are hospitals with an average Medicare inpatient length of stay of greater than 25 days, including all covered and non-covered days of stay of Medicare patients. The 25 day Medicaid ALOS requirement has been waived for some pilot programs. They provide treatment to patients with complex medical conditions, such as strokes, cardiac care, ventilator dependency, wound care and post-surgical care. Medicare pays for about 73% of all LTACH discharges; the standard federal reimbursement for 2009 was $39,114.36 per patient.

There are more than 350 LTACHs nationwide, and they may be either a freestanding facility, or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional Federal criteria in order to qualify as a LTACH Hospital under the "hospital-within-a-hospital" model:

1) The new hospital must have a governing body, which is distinct and separate from the governing body of the host hospital, and the new body cannot be under the control of the host hospital or any third entity that controls both hospitals.

2) The LTACH must have a separate Chief Executive Officer through whom all administrative authority flows, who is not employed by, or under contract with, the host hospital or any third entity that controls both hospitals.

3) The hospital must have a separate Chief Medical Officer who reports directly to the governing body and is responsible for all medical staff activities. The Chief Medical Officer cannot be under contract with the host hospital or any third entity that controls both hospitals.

4) The hospital must have a separate medical staff from the medical staff of the host hospital, which report directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

LTACHs have their own Prospective Payment System (PPS). In 2006, CMS established a "25% payment threshold policy" for LTACHs. For the current details of the policy consult 42 CFR 412.534(c)(1).

CMS had proposed revising the reimbursement policy and extending the 25% rule to all LTACHs; if any LTACH gets more than 25% of its admissions from a single hospital it will receive less reimbursement. However, under Health Reform, regulatory relief from the 25% rule and a moratorium on the development of new facilities was extended to 2012. The LTACH DRGs were re-weighted in 2009 and CMS provided a 2% payment increase for FY 2010.

The existing LTACHs in South Carolina and their occupancy rates are:

FACILITY	COUNTY	BEDS	2007	2008	2009
NORTH GREENVILLE LONG TERM ACUTE	GREENVILLE	45	48.6	58.0	62.3
REGENCY HOSPITAL OF GREENVILLE	GREENVILLE	32	78.6	74.2	71.6
SPARTANBURG HOSP RESTORATIVE CARE	SPARTANBURG	97	36.1	33.2	34.6
INTERMEDICAL HOSPITAL OF SC	RICHLAND	35	75.5	66.0	67.9
REGENCY HOSPITAL OF SOUTH CAROLINA	FLORENCE	40	86.4	73.7	77.0
KINDRED HOSPITAL CHARLESTON	CHARLESTON	59	50.8	50.4	46.0
	TOTAL	308			

Certificate of Need Standards

(1) An application for a Long Term Acute Care Hospital must be in compliance with the relevant standards in Regulation No. 61-16, Licensing Standards for Hospital and Institutional General Infirmaries.

(2) Although Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

(3) The utilization of LTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Long Term Acute Care Hospital beds. An applicant must document the need for LTACH beds based on the utilization of existing LTACH beds.

(4) A hospital that has leased general beds to a Long Term Acute Care Hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required:

A. a hospital may be allowed to convert these former LTACH beds to general acute hospital beds regardless of the projected need for general acute beds;

B. a hospital may be allowed to convert these former LTACH beds to psychiatric, inpatient treatment facility, rehabilitation, or other specialty beds only if there is a bed need projected for this proposed other category of licensed beds.

(5) A hospital which desires to be designated as an LTACH and has been awarded a CON for that purpose, must be certified as an LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.

Quality

The DHEC Hospital Acquired Infections (HAI) report includes a standardized Central Line Associated Blood Stream Infections (CLABSI) ratio for LTACHs. Each LTACH is compared to the national standard population of hospitals entering HAI data into the National Healthcare Safety Network (NHSN) database. The Standardized Infection Ratio (SIR) is a summary measure used to compare the CLABSI experience among a group of reported locations to that of a standard population. It is the observed number of infections divided by the expected (predicted) number of infections. For HAI reports, the standard population comes from NHSN data reported from all hospitals using the system in the United States. The "expected" number of infections is based on historical data for those procedures at the national level. All South Carolina LTACHs should be lower than, or not different from, their statistically expected ratios. The report is accessible online at: http//www.scdhec.gov /health/ disease/ hai/docs/ Table%207.20Long% 20Term% 20Acute%20Care%20Unit.pdf. The Department may use the HAI report in evaluating a CON application for additional LTACH beds at an existing facility.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

Long Term Acute Care Hospital beds are located within approximately sixty (60) minutes travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

C. Critical Access Hospitals:

Rural counties tend to have higher unemployment and a preponderance of low-paying jobs that do not provide health insurance; a greater percentage of their population are elderly. Rural hospitals are usually smaller than urban hospitals, with fewer physicians and other health care professionals, and diagnostic and therapeutic technology is generally less available. They typically have a high Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.

The Medicare Rural Hospital Flexibility Program allows the designation of Critical Access Hospitals (CAHs). These hospitals are eligible for cost-based reimbursement without having to meet all criteria for full-service acute care hospitals. They are intended to provide essential health services to rural communities; converting a struggling rural hospital to a CAH can allow a community to maintain local health access that would otherwise be lost.

The following criteria must be met in order for a facility to qualify as a CAH:

(1) It must be located in a rural county. It may be either an existing facility or a hospital that closed or downsized to a health center or clinic after November 29, 1989. A facility may be allowed to relocate or rebuild provided it meets the CMS criteria.

(2) The facility must be part of a rural health network with at least one full-service hospital, with agreements regarding patient referral and transfer, communications, and patient transportation;

(3) The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or must have been certified by the State prior to January 1, 2006 as being a necessary provider of health care services to residents of the area;

(4) The maximum number of licensed beds is 25, which can be operated as any combination of acute or swing-beds;

(5) Required services include: inpatient care, emergency care, laboratory and pharmacy;

(6) Emergency services must be available 24 hours a day, with on-call personnel available within 30 minutes. CMS requires that any hospital, including a CAH, that does not have a physician on site 24 hours per day, 7 days per week, provide a notice to all patients upon admission that addresses how emergency services are provided when a physician is not on site.

(7) The medical staff must consist of at least one physician. Staffing must include nursing on a 24-hour basis; other staffing can be flexible. Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists can provide inpatient care without their supervising physician(s) being on-site.

(8) The annual average length of stay must be less than 96 hours (4 days).

In South Carolina, a hospital located in an urban Metropolitan Statistical Area (MSA) county can still be considered "rural" for the purposes of the CAH program if it meets the following criteria:

(1) It is enrolled as both a Medicaid and Medicare provider and accepts assignment for all Medicaid and Medicare patients;

(2) It provides emergency health care services to indigent patients;

(3) It maintains a 24-hour emergency room;

(4) It staffs 50 or fewer acute care beds; and

(5) It is located in a county with 25% or more rural residents, as defined by the most recent Census.

A total of 1,305 hospitals nationwide had been approved for CAH status as of July 2009. The impact of the Critical Access Hospital Program in South Carolina is a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH does not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25-bed requirement.

The following facilities in South Carolina are designated as CAHs, although there are other hospitals that could potentially be eligible:

Abbeville Memorial Hospital
Allendale County Hospital
Edgefield County Hospital
Fairfield Memorial Hospital
Williamsburg Regional Hospital

The designation of a hospital as a Critical Access Hospital does not require Certificate of Need review, because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce the number of licensed beds in order to meet the criteria for a CAH. Should a hospital later desire to revert to a general acute hospital, a Certificate of Need is required, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds.

D. Obstetrical and Neonatal Services:

1. Obstetrical Services:

Advances in obstetrical and newborn intensive care offer the promise of lower perinatal mortality and improvement in the quality of life for survivors. The high cost of intensive care and the limited availability of skilled personnel have created the requirement for a more efficient method of resource allocation.

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries are a small percent of total annual deliveries, but these patients require a high degree of specialized care. In 2007, 77.7% of all Very Low Birthweight (VLB) babies were born in either a Level III center or a Regional Perinatal Center.

Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 2008 was 8.0 infant deaths per 1,000 live births, while the national Healthy People 2010 objective for of no more than 4.5 infant deaths per 1,000 births.

Neonatal mortality is the death rate for infants up to 28 days old. For 2008, South Carolina's neonatal mortality rate for all races was 4.9 neonatal deaths per 1,000 live births versus the Healthy People 2010 national objective of 2.9 neonatal deaths per 1,000 live births.

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the state to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services is designated by DHEC's Division of Health Licensing as a Level I, II, IIE (Enhanced), III Perinatal Hospital, or a RPC (Regional Perinatal Center). Each Level I, II, IIE and III hospital maintains a relationship with its designated RPC for consultation, transport and continuing education. Patients are transferred to the appropriate RPC when medically appropriate, if beds are available. In this way, quality care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The complete descriptions of the five levels of perinatal services are outlined in Section 607.2 of Regulation Number 61-16: http://www.scdhec.net/administration/regs/docs/61-16.pdf

Community Perinatal Center (Level I): These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital has the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2,000 grams. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for immediate transfer to a higher level hospital. CON review is not required for a Level I program.

Specialty Perinatal Center (Level II): In addition to Level I requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. This level of neonatal care includes the management of neonates who are at least 32 weeks of gestation with an anticipated birth weight of at least 1,500 grams. A board-eligible pediatrician must be in the hospital or on site within 30 minutes, 24 hours a day and the hospital must have at least a written consultative agreement with a board eligible neonatologist. These hospitals manage a three year average of at least 500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. CON review is not required for a Level II program.

Enhanced Perinatal Center (Level IIE): In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may not be located closer than 60 miles from a Regional Perinatal Center. This level of care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1,250 grams. A board-eligible neonatologist must be in the hospital or on site within 30 minutes, 24 hours a day. These hospitals manage a three year average of at least 1,200 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (Level IIE) services.

Subspecialty Perinatal Center (Level III): In addition to Level IIE requirements, these hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified perinatologist shall be available for supervision and consultation, 24 hours a day. Level III hospitals have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. These hospitals manage a three year average of at least 1,500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals, or at least an average of 125 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. The establishment of a Level III service requires Certificate of Need review.

Regional Perinatal Center (RPC): In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC shall provide consultative, outreach, and support services to other hospitals in the region. RPCs manage a three year average of at least 2,000 deliveries annually, or at least an average of 250 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. A board-certified maternal-fetal medicine specialist (perinatologist) must be in the hospital or on site within 30 minutes, 24 hours a day. RPCs participate in residency programs for obstetrics, pediatrics, and/or family practice. No more than one Regional Perinatal Center will be approved in each perinatal region. The establishment of a Regional Perinatal Center requires Certificate of Need review.

2009 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEMORIAL MEDICAL CENTER	5,083	59	8,245	16,879	78.4%
PALMETTO HEALTH BAPTIST	3,620	82	5,695	10,453	34.9%
LEXINGTON MEDICAL CENTER	3,178	29	3,444	7,062	66.7%
SPARTANBURG REGIONAL MEDICAL CTR.	2,928	43	3,276	7,503	47.8%
SAINT FRANCIS - EASTSIDE	2,546	35	2,651	6,439	50.4%
MUSC MEDICAL CENTER	2,541	26	2,885	8,441	88.9%
PALMETTO HEALTH RICHLAND	2,466	48	5,799	12,148	69.3%
TRIDENT MEDICAL CENTER	2,130	25	2,342	5,212	57.1%
PIEDMONT MEDICAL CENTER	2,112	19	2,204	5,600	80.7%
ANMED HEALTH WOMEN'S & CHILDREN'S	2,187	28	1,788	4,872	47.7%
MCLEOD REGIONAL MEDICAL CTR.	2,166	35	2,696	7,137	55.9%
BON SECOURS ST. FRANCIS XAVIER	1,996	15	2,067	4,735	86.5%
BEAUFORT MEMORIAL HOSPITAL	1,795	23	1,657	4,581	54.6%
EAST COOPER MEDICAL CENTER	1,692	27	2,116	4,991	50.6%
SELF REGIONAL HEALTHCARE	1,550	37	2,312	5,981	44.3%
CONWAY HOSPITAL	1,419	16	1,542	3,554	60.9%
REG MED CTR ORANGEBURG-CALHOUN	1,355	27	1,578	4,464	45.3%
AIKEN REGIONAL MEDICAL CENTER	1,213	18	1,676	4,340	66.1%
TUOMEY	1,282	24	656	4,836	55.2%
MARY BLACK MEMORIAL HOSPITAL	1,142	21	1,258	3,058	39.9%
SUMMERVILLE MEDICAL CENTER	1,146	12	999	2,057	47.0%
GRAND STRAND REGIONAL MED CTR	883	19	1,183	2,501	36.1%
WOMEN'S CENTER / CAROLINAS HOSP. SYS	935	20	842	3,483	47.7%
CLARENDON MEMORIAL	815	10	819	1,837	50.3%
HILTON HEAD HOSPITAL	743	8	832	1,946	66.6%
SPRINGS MEMORIAL HOSPITAL	740	14	133	231	4.5%
ROPER HOSPITAL	457	16	669	1,610	27.6%
CAROLINA PINES REGIONAL MED CTR	609	13	1,013	2,545	53.6%
PALMETTO BAPTIST MED CTR EASLEY	557	14	809	1,944	38.0%
PROVIDENCE HOSPITAL NORTHEAST	622	6	590	1,405	64.2%
WACCAMAW COMMUNITY HOSPITAL	635	19	1,884	4,947	71.3%
OCONEE MEDICAL CENTER	542	16	428	1,625	27.8%
ALLEN BENNETT/GREER MEMORIAL	582	10	1,037	1,465	40.0%
GEORGETOWN MEMORIAL HOSPITAL	417	14	977	2,522	49.4%
COLLETON MEDICAL CENTER	442	6	439	998	45.6%
KERSHAW HEALTH	435	10	654	1,550	42.5%
LORIS COMMUNITY HOSPITAL	400	8	561	1,200	41.1%
NEWBERRY COUNTY MEMORIAL HOSPITAL	401	3	456	891	81.4%
LAURENS COUNTY HOSPITAL	431				
UPSTATE CAROLINA MEDICAL CENTER	417	15		1,298	23.7%
MARION REGIONAL HOSPITAL	399				
MCLEOD MEDICAL CENTER - DILLON	350	14	384	921	18.0%
CHESTERFIELD GENERAL HOSPITAL	178	9	235	599	18.2%
MARLBORO PARK HOSPITAL	128	8	265	590	20.2%
ABBEVILLE COUNTY MEMORIAL HOSPITAL	47	3	51	110	10.0%
WALLACE THOMSON HOSPITAL	100	4	131	281	19.2%
BAMBERG COUNTY MEMORIAL HOSPITAL					
HAMPTON REGIONAL MEDICAL CTR	5				
TOTAL BIRTHS	57,817				

The need for obstetrical beds will be evaluated based on information supplied by the Joint Annual Report of Hospitals and other sources. Those facilities experiencing low utilization and in close proximity to one another should consider consolidating services, where appropriate.

Quality

Cesarean sections are identified as a potentially over-used procedure, although an optimal rate has not been determined. While the appropriateness of a c-section depends on the patient's characteristics, it is largely impacted by the individual physician's practice patterns. Hospital rankings need to be risk-adjusted, but, overall, a lower c-section rate is viewed as representing higher quality. Conversely, a higher rate of Vaginal Birth After Cesarean (VBAC) equates to higher quality. To the extent practical, hospitals should attempt to lower their c-section rates.

Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

Relative Importance of Project Review Criteria

The following project review criteria are considered the most important in evaluating Certificate of Need applications for an obstetrical service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

The following hospitals have requested a Perinatal Capability Review and have been designated as a Level II, Level IIE, Level III or RPC facility:

Regional Perinatal Centers

Greenville Memorial Medical Center
McLeod Regional Medical Center of the Pee Dee
MUSC Medical Center
Palmetto Health Richland
Spartanburg Regional Medical Center

Subspecialty Perinatal Center (Level III Hospital)

Palmetto Health Baptist
Self Regional Healthcare

Enhanced Perinatal Center (Level II Enhanced Care Hospitals)

Piedmont Medical Center

Specialty Perinatal Centers (Level II Hospitals)

Aiken Regional Medical Center
AnMed Health Women's and Children's Hospital
Baptist Easley Hospital
Beaufort Memorial Hospital
Bon Secours-St. Francis Xavier Hospital
Carolina Pines Regional Medical Center
Conway Hospital
East Cooper Medical Center
Georgetown Memorial Hospital
Grand Strand Regional Medical Center
Lexington Medical Center
Marion County Medical Center
Mary Black Memorial Hospital
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital
St. Francis - Eastside
Springs Memorial Hospital
Summerville Medical Center
Trident Medical Center
Tuomey
Waccamaw Community Hospital
The Women's Center of Carolinas Hospital System

2. Neonatal Services:

Neonatal services are highly specialized and are only required by a very small percentage of infants. The need for these services is affected by the incidence of high-risk deliveries, the percentage of live births requiring neonatal services, and the average length of stay. The limited need for these services requires that they be planned for on a regional basis, fostering the location of these specialized units in hospitals that have the necessary staff, equipment, and consultative services and facilities. Referral networks facilitate the transfer of infants requiring this level of services from other facilities.

The inventory of Intensive and Intermediate Bassinets by Perinatal Region is as follows:

Perinatal Region	Existing Bassinets Intensive	Intermediate
Anderson, Abbeville, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda		
Palmetto Baptist Medical Center - Easley	0	4
Greenville Memorial Medical Center	12	68
AnMed Health Women's & Children's Hospital	0	13
St. Francis Women's & Family Hospital	0	10
Self Regional Healthcare	7	11
SUBTOTAL	19	106
Cherokee, Chester, Spartanburg, Union		
Spartanburg Regional Medical Center	13	22
Mary Black Memorial Hospital	0	10
SUBTOTAL	13	32
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, York		
Palmetto Health Richland	31	34
Palmetto Health Baptist	8	22
Lexington Medical Center	0	20
Piedmont Medical Center	0	12
Springs Memorial Hospital	0	4
Aiken Regional Medical Center	0	8
Regional Med Center Orangeburg-Calhoun	0	10
Tuomey	0	22
SUBTOTAL	39	132
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Carolina Pines Regional Medical Center	0	4
Marion County Medical Center	0	2
McLeod Regional Medical Ctr. of Pee Dee	12	28
Conway Hospital	0	6
Grand Strand Regional Medical Center	0	2
Women's Center of Carolinas Hospital System	0	11
SUBTOTAL	12	53
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	5
Georgetown Memorial Hospital	0	5
Waccamaw Community Hospital	0	2
MUSC Medical Center	16	50
East Cooper Medical Center	0	10
Bon Secours-St. Francis Xavier Hospital	0	11
Summerville Medical Center	0	3
Trident Medical Center	0	10
Roper Hospital	0	5
SUBTOTAL	16	101
STATEWIDE TOTAL	99	424

The 2009 utilization of neonatal special care units by facility follows. Note that some facilities did not report using any of their intermediate care bassinets.

HOSPITAL	ICU Bassinets	ICU Pt Days	Intermed Bassinets	Intermed Pt Days	Total Bassinets	Total Pt Days	Total Occupancy
AnMed Health Women's			13	999	13	999	21.1%
Greenville Memorial	12	5,499	68	13,795	80	19,294	66.1%
St. Francis-Eastside			10	2,216	10	2,216	60.7%
Palmetto Baptist-Easley			4	0	4	0	0.0%
Self Regional	7	556	11	2,349	18	2,905	44.2%
REGION SUBTOTAL	19	6,055	106	19,359	125	25,414	55.7%
Mary Black Memorial			10	713	10	713	19.5%
Spartanburg Regional	13	6,553	22	3,575	35	10,128	79.3%
REGION SUBTOTAL	13	6,553	32	4,288	45	10,841	66.0%
Aiken Regional Med Ctr			8	314	8	314	10.8%
Springs Memorial Hosp			4	805	4	805	55.1%
Lexington Medical Ctr			20	2,850	20	2,850	39.0%
Reg Med Ctr Orangeburg			10	0	10	0	0.0%
Palmetto Health Baptist	8	1,510	22	4,152	30	5,662	51.7%
Palmetto Health Richland	31	9,190	34	12,668	65	21,858	92.1%
Tuomey			22	545	22	545	6.8%
Piedmont Medical Ctr			12	1,440	12	1,440	32.88%
REGION SUBTOTAL	39	10,700	132	22,774	171	33,474	53.63%
Carolina Pines Regional			4	111	4	111	7.6%
McLeod Regional	12	4,319	28	4,853	40	9,172	62.8%
Women's Ctr Carolinas			11	1,015	11	1,015	25.3%
Conway Hospital			6	611	6	611	27.9%
Grand Strand Regional			2	209	2	209	28.6%
Marion Co Medical Ctr			2	0	2	0	0.0%
REGION SUBTOTAL	12	4,319	53	6,799	65	11,118	46.9%
Beaufort Memorial Hosp			5	0	5	0	0.0%
Bon Secours-St. Francis			11	1,238	11	1,238	30.8%
East Cooper Medical Ctr			10	366	10	366	10.0%
MUSC Medical Center	16	7,605	50	11,305	66	18,910	78.5%
Roper Hospital			5	110	5	110	6.0%
Trident Medical Center			10	2,139	10	2,139	58.6%
Summerville Med. Ctr.			3	1,112	3	1,112	101.6%
Georgetown Memorial			5	137	5	137	7.5%
Waccamaw Community			2	483	2	483	66.2%
REGION SUBTOTAL	16	7,605	101	16,890	117	24,495	57.4%
GRAND TOTAL	99	35,232	424	70,110	523	105,342	55.2%

The projected need for neonatal intensive care bassinets is calculated based on the utilization of the individual Level III and Regional Perinatal Centers using a 65% occupancy factor. This allows for a potential increase in bassinets given the small number of bassinets needed. In most areas, the utilization of intensive care bassinets is high and there is a need for additional intensive care bassinets. Only Level III and RPCs neonatal units have intensive care bassinets.

The projected need for intermediate neonatal bassinets was calculated using the preceding methodology. Note that some Level II hospitals did not report any utilization for the intermediate care bassinets and the occupancy rate is reflected as zero, which decreases the need calculations. The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

Note: S.C. presently has 1.6 neonatal intensive care bassinets and 6.8 neonatal intermediate care bassinets per 1,000 births.

In some areas the number of intensive care bassinets should be increased. The intermediate care bassinets should be better utilized in Level II and Level IIE facilities so babies can be transferred back closer to their home community potentially alleviating the high utilization of the current intensive/intermediate care bassinets in RPC facilities in some areas of the State. To improve the availability of the existing RPC neonatal intensive care bassinets, utilization of the back transport concept should be supported. This component of regionalized care involves the transfer of infants who no longer require neonatal intensive care to facilities with intermediate or continuing care bassinets appropriate to the individual baby's care needs. If more back transfers to the Level II and/or Level IIE facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

It should be noted that some RPC and Level III facilities with intensive care bassinets may at times have intermediate type infants in intensive care bassinets and vice versa as the patient load changes within the unit. RPCs may use intermediate and intensive care bassinets interchangeably as the level of care required by the neonate varies.

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for a neonatal service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the very small percentage of infants requiring neonatal services, this service is available within approximately 90 minutes for the majority of the population. Of more importance is the early identification of mothers who

potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is a need for additional intensive care bassinets in some areas. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals. The benefits of improved accessibility will be equally weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

NICU BASSINET CALCULATIONS

Hospital (RPC)	Existing Bassinets	2009 Pt Days	NICU ADC	Occupancy Factor	Projected Need	To Be Added
Greenville Memorial	12	5,499	15	0.65	23	11
Spartanburg Regional	13	6,553	18	0.65	28	15
Self Regional	7	556	2	0.65	2	-5
Palmetto Health Richland	31	9,190	25	0.65	39	8
Palmetto Health Baptist	8	1,510	4	0.65	6	-2
McLeod Regional	12	4,319	12	0.65	18	6
MUSC Medical Center	16	7,605	21	0.65	32	16
Totals	99	35,232	96		148	49

INTERMEDIATE BASSINET NEED

Hospital	Intermed Bassinets	2009 Pt Days	Intermed ADC	Occupancy Factor	Projected Need	To Be Added
AnMed Health Women's	13	999	3	0.65	4	-9
Greenville Memorial	68	13,795	38	0.65	58	-10
St. Francis-Eastside	10	2,216	6	0.65	9	-1
Palmetto Baptist-Easley	4	0	0	0.65	0	-4
Spartanburg Regional	22	3,575	10	0.65	15	-7
Mary Black Memorial	10	713	2	0.65	3	-7
Self Regional	11	2,349	6	0.65	10	-1
Aiken Regional Med Ctr	8	314	1	0.65	1	-7
Springs Memorial Hosp	4	805	2	0.65	3	-1
Lexington Medical Ctr	20	2,850	8	0.65	12	-8
Reg Med Ctr Orangeburg	10	0	0	0.65	0	-10
Palmetto Health Baptist	22	4,152	11	0.65	17	-5
Palmetto Health Richland	34	12,668	35	0.65	53	19
Tuomey	22	545	1	0.65	2	-20
Piedmont Medical Ctr	12	1,440	4	0.65	6	-6
Carolina Pines Regional	4	111	0	0.65	0	-4
McLeod Regional Med Ctr	28	4,853	13	0.65	20	-8
Women's Ctr Carolinas	11	1,015	3	0.65	4	-7
Conway Hospital	6	611	2	0.65	3	-3
Grand Strand Regional	2	209	1	0.65	1	-1
Marion Co Medical Ctr	2	0	0	0.65	0	-2
Beaufort Memorial Hosp	5	0	0	0.65	0	-5
Bon Secours-St. Francis	11	1,238	3	0.65	5	-6
East Cooper Med Ctr	10	366	1	0.65	2	-8
MUSC Medical Center	50	11,305	31	0.65	48	-2
Roper Hospital	5	110	0	0.65	0	-5
Trident Medical Center	10	2,139	6	0.65	9	-1
Summerville Med. Ctr.	3	1,112	3	0.65	5	2
Georgetown Memorial	5	137	0	0.65	1	-4
Waccamaw Community	2	483	1	0.65	2	0
Totals	424	70,110	192		295	-129

E. Pediatric Inpatient Services:

A pediatric inpatient unit is a specific section, ward, wing or unit devoted primarily to the care of medical and surgical patients less than 18 years old, not including special care for infants. It is recognized that children have special problems that need to be addressed by specialized facilities, equipment and personnel experienced in dealing with children, and understanding and sympathetic to the child's unique needs. It is also recognized that each hospital need not develop the capability to provide all types of pediatric care. Pediatric beds are licensed as general hospital beds and no separate need is calculated for them.

Quality

The Agency for Health Research and Quality (AHRQ) lists 13 provider-level quality indicators for pediatric services. Not all indicators are applicable for all hospitals. These include: accidental puncture and laceration; decubitus ulcer; foreign body left in during a procedure; iatrogenic pneumothorax in neonates and non-neonates; in-hospital mortality for pediatric heart surgery; volume of pediatric heart surgery; post-operative hemorrhage or hematoma; post-operative respiratory failure; post-operative sepsis; post-operative wound dehiscence (opening of a wound along the suture line); infection due to medical care; and transfusion reaction. South Carolina hospitals should be lower than or comparable to the national averages for these indicators.

Link: http://www.qualityindicators.ahrq.gov/downloads/pdi/2006-Feb-PediatricQualityIndicators.pdf

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

In many hospitals, pediatric beds/services are not physically separated from other general hospital beds. Only larger hospitals have distinct pediatric units. General hospital beds are located within approximately 30 minutes travel time for the majority of the residents of the State. There may be a need for additional pediatric beds in the existing general hospitals; however, additional beds for pediatric services will not be approved unless other beds are converted to pediatrics or a need is indicated in the Plan for additional hospital beds. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of this existing service.

F. Pediatric Long Term Acute Care Hospitals:

Pediatric Long Term Care Hospitals (PLATCHs) are specialized health care facilities designed to provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis (similar to adult LTACHs). Care may be rehabilitative or palliative. These facilities are designed to be as non-institutional as possible while meeting the psychological, physical, and emotional needs of chronically ill children and their families. To be admitted, children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services.

Patients often have three or more chronic conditions. These may include Neonatal Abstinence Syndrome (NAS), birth defects, spinal cord or trauma injury, seizure disorders, chronic lung disease, and extensive wound care. Many are non-ambulatory and dependent on medical technology such as ventilators, feeding tubes, IV infusions, and mobility devices.

The DHEC Division of Children with Special Health Care Needs has a caseload of approximately 12,000 children and it is envisioned that many of these clients would be candidates for Pediatric LTACH services. These patients are currently either staying for extended periods in one of the state's Children's Hospitals (Greenville Hospital System, Palmetto Health, McLeod, and MUSC) or are receiving daily therapy in their own homes. Neither option is optimal for these patients.

Pediatric LTACH facilities are currently located primarily in the Northeast and California. They are potentially a less costly alternative to maintaining these children in an acute care facility. Some states have nursing homes that specialize in extended care for pediatric patients, but there are currently no such facilities in South Carolina.

Certificate of Need Standards

1. An application for a Pediatric Long Term Acute Care Hospital must be in compliance with the relevant standards in DHEC Regulation No. 61-16, Licensing Standards for Hospitals and Institutional General Infirmaries.

2. Although Pediatric Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of PLTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Pediatric Long Term Acute Care Hospital beds. An applicant must document the need for PLTACH beds.

4. An applicant for PLTACH beds must submit an affiliation agreement with a SC Children's Hospital. This affiliation agreement will at a minimum include a transfer agreement and coverage for specialized medical services.

5. Should a hospital lease general beds to another entity to create a Pediatric Long Term Acute Care Hospital, that hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Pediatric Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required.

6. A hospital that desires to be designated as a Pediatric LTACH must restrict admissions to patients under the age of 21 who require long-term medical care. Once licensed, a Pediatric LTACH must remain licensed as such. Should the facility attempt to provide care that is inconsistent with this requirement or patient demand or other economic conditions require the facility to close, the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital and the licensed beds operated by the facility will be removed from the bed inventory.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

There are currently no Pediatric Long Term Acute Care Hospital beds in South Carolina. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

CHAPTER IV

PSYCHIATRIC SERVICES

A. Community Psychiatric Beds:

Inpatient psychiatric services are those services provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.

Special units for children and adolescents and geriatric patients have been developed throughout the state. If any additional beds are approved, they must come from the overall psychiatric bed component shown as needed. These specialty psychiatric services should be identifiable units with sufficient space to have available areas for sleeping, dining, education, recreation, occupational therapy and offices of evaluation and therapy. The unit should be staffed with an appropriate multi-disciplinary care team of psychiatrists, psychologists, social workers, nurses, occupation therapists, recreational therapists, and psychiatric technicians. Other consultants should be available as needed.

The following psychiatric programs are currently available:

Region	Facility	County	Beds	2009 Occupancy	
I	AnMed Health Medical Ctr.	Anderson	38	43.0%	
I	Carolina Ctr. Behavioral Health	Greenville	99	87.6%	*1*
I	Greenville Memorial Med. Ctr.	Greenville	46	85.1%	
I	Springbrook Behavioral Health	Greenville	37	64.1%	*2*
I	Mary Black Memorial	Spartanburg	15	73.3%	
I	Spartanburg Regional Med. Ctr.	Spartanburg	56	24.4%	
II	Self Memorial Regional	Greenwood	36	34.1%	
II	Three Rivers Behavioral Health	Lexington	81	69.3%	*3*
II	Palmetto Health Baptist	Richland	94	60.6%	*3*
II	Palmetto Health Richland	Richland	60	30.2%	
II	Piedmont Medical Center	York	20	46.9%	
III	McLeod – Darlington	Darlington	23	55.5%	
III	Carolinas Hospital System	Florence	12	55.0%	
III	Lighthouse of Conway	Horry	59	72.5%	*4*
III	Marlboro Park Hospital	Marlboro	8	0.0%	
IV	Aiken Regional Med. Ctr.	Aiken	41	99.2%	*5*
IV	Beacon Harbor	Beaufort	22	---	*6*
IV	Beaufort Memorial	Beaufort	14	48.8%	
IV	Medical University SC	Charleston	82	63.6%	
IV	Palmetto Lowcountry Behavioral	Charleston	70	62.7%	
IV	RMC – Orangeburg & Calhoun	Orangeburg	15	59.9%	
		Total	928	60.3%	

1 CON issued 8/10/09 to add 23 beds for a total of 99; 8 additional beds licensed for a total of 84 2/16/10.

2 CON issued 8/10/09 to add 17 beds for a total of 37.

3 CON issued 2/13/08 to transfer 10 psych beds from Palmetto Baptist to Three Rivers in exchange for 10 substance abuse beds to be transferred to Palmetto Baptist. Three Rivers licensed for 81 beds 7/10/09. Palmetto Baptist licensed for 94 beds 7/21/08.

4 CON issued 1/25/10 to add 15 beds for a total of 59.

5 CON issued 8/12/10 for the addition of 12 psych beds for a total of 41.

6 CON issued 8/13/10 to construct a 22 bed psychiatric hospital.

Certificate of Need Standards

1. Need projections are based on psychiatric service areas.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or 75% of the statewide average beds per 1,000 population to project need.

3. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projections.

4. Priority should be given to excess general hospital beds that can be economically and cost effectively converted for use as a specialized psychiatric unit over the construction of new beds, if such beds will be accessible to the target population.

Quality

The Hospital-Based Inpatient Psychiatric Services (HBIPS) project grew from a partnership among the National Association of Psychiatric Health Systems, the National Association of State Mental Health Program Directors, the American Psychiatric Association and the Joint Commission. The HBIPS core measures focus on critical issues that affect the course of a patient's hospitalization, such as admissions screening and having a coordinated plan for continuity of treatment. Other measures address the use of anti-psychotic medications and the reduction in the use of restraints and seclusion. Collection and reporting of these measures are expected to become mandatory starting in 2013, and pilot testing of pay-for-performance measures by 2016. All South Carolina hospitals that offer inpatient psychiatric services should support the HBIPS project and be in compliance with its core measures.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2009 POP	2016 POP	EXISTING BEDS	2009 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	BED NEED
ANDERSON,OCONEE	<65	213,830	223,140		4,228	12.09						
	+65	39,400	47,900		1,735	5.78						
	TOTAL	253,230	271,040	38	5,963	17.87	0.70	26	-12	43	5	5
GREENVILLE,PICKENS	<65	478,300	509,470		35,659	104.06						
	+65	63,650	76,890		8,098	26.80						
	TOTAL	541,950	586,360	182	43,757	130.86	0.70	187	5	93	-89	5
CHEROKEE,SPARTANBURG	<65	317,950	331,180		3,712	10.59						
UNION	+65	46,830	56,010		5,289	17.33						
	TOTAL	364,780	387,190	71	9,001	27.92	0.70	40	-31	61	-10	-10
CHESTER,LANCASTER	<65	255,300	271,990		3,089	9.02						
YORK	+65	32,950	41,020		335	1.14						
	TOTAL	288,250	313,010	20	3,424	10.16	0.70	15	-5	49	29	29
ABBEVILLE,EDGEFIELD	<65	199,270	206,880		4,025	11.45						
GREENWOOD,LAURENS	+65	33,370	41,160		462	1.56						
MCCORMICK,SALUDA	TOTAL	232,640	248,040	36	4,487	13.01	0.70	19	-17	39	3	3
FAIRFIELD,KERSHAW	<65	633,440	665,770		36,782	105.92						
LEXINGTON,NEWBERRY	+65	79,470	101,640		8,607	30.16						
RICHLAND	TOTAL	712,910	767,410	235	45,389	136.08	0.70	194	-41	121	-114	-41
DARLINGTON,FLORENCE	<65	208,940	210,080		4,453	12.27						
MARION	+65	30,020	37,510		2,612	8.94						
	TOTAL	238,960	247,590	35	7,065	21.21	0.70	30	-5	39	4	4
CHESTERFIELD,DILLON	<65	89,590	88,050		0	0.00						
MARLBORO	+65	12,360	14,770		0	0.00						
	TOTAL	101,950	102,820	8	0	0.00	0.70	0	-8	16	8	8
CLARENDON,LEE,SUMTER	<65	147,320	149,650		0	0.00						
	+65	23,280	29,180		0	0.00						
	TOTAL	170,600	178,830	0	0	0.00	0.70	0	0	28	28	28
GEORGETOWN,HORRY	<65	273,790	290,730		5,313	23.02						
WILLIAMSBURG	+65	58,610	78,660		6,326	11.62						
	TOTAL	332,400	369,390	59	11,639	34.64	0.70	49	-10	58	-1	-1
BAMBERG,CALHOUN	<65	109,840	109,610		1,741	4.76						
ORANGEBURG	+65	18,500	22,930		963	3.27						
	TOTAL	128,340	132,540	15	2,704	8.03	0.70	11	-4	21	6	6
ALLENDALE,BEAUFORT	<65	163,750	171,620		1,595	4.58						
HAMPTON,JASPER	+65	37,140	52,030		897	3.44						
	TOTAL	200,890	223,650	36	2,492	8.02	0.70	11	-25	35	-1	-1
BERKELEY,CHARLESTON	<65	565,810	579,760		31,775	89.20						
COLLETON,DORCHESTER	+65	81,350	109,230		3,266	12.01						
	TOTAL	647,160	688,990	152	35,041	101.22	0.70	145	-7	109	-43	-7
AIKEN,BARNWELL	<65	161,210	170,170		8,879	25.68						
	+65	25,960	32,500		1,619	5.55						
	TOTAL	187,170	202,670	41	10,498	31.14	0.70	44	3	32	-9	3
	TOTAL			928				771	-157	746	-182	33
STATE TOTAL	<65	3,818,340	3,978,100	0.000158	141,252	0.038477458	0.03					
	+65	582,890	741,430		40,208	0.071850901	0.05					
	TOTAL	4,401,230	4,719,530		181,460	0.0429	0.03					

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Psychiatric beds are planned for and located within sixty (60) minutes travel time for the majority of the residents of the State. In addition, current utilization and population growth are factored into the methodology for determining psychiatric bed need. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these services.

B. State Mental Health Facilities:

1. Psychiatric Hospital Beds:

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and expansion of the component programs should be allowed as long as the overall psychiatric hospital complement is maintained or reduced. As long as the Department of Mental Health does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, any changes in facility bed capacity are exempt from Certificate of Need review.

2. Local Inpatient Crisis Stabilization Beds:

Because the South Carolina Department of Mental Health (SCDMH) has had substantial decreases over the past several years in inpatient capacity, insufficient adult inpatient beds are available to meet the demand from referral sources for its beds. In a number of regions of the State, this has led to significant numbers of persons in a behavioral crisis waiting in hospital emergency rooms inordinate periods of time for an appropriate inpatient psychiatric bed to become available. These emergency room patients may not have a source of funding.

SCDMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program." Within available funding limits, the "Crisis Stabilization Program" is to provide short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs, such as community residential care facilities, for those patients who do not require a hospital level of care. For patients needing stabilization in a hospital, subject to available funding, the SCDMH contracts with one or more local hospitals willing to admit indigent patients assessed by the SCDMH mental health center as needing acute care in return for a

daily rate for a defined period. These patients can be cared for in licensed general acute care beds or licensed psychiatric beds.

Due to the low utilization, the Plan only projects a need for a small number of additional psychiatric beds in some service areas. To assist in alleviating the problems described above, the following policies will apply.

1. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services in existing acute care or existing psychiatric beds, then a Certificate of Need is not required.

2. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services and desire to add psychiatric beds, a Certificate of Need is required. These additional beds could be approved if the Plan indicates a need for additional beds or some small number (ten beds or less) of additional beds could be approved for crisis stabilization patients only. These beds would not be restricted to any specific age group except that the patients would have to be over age 18.

3. An application for a Certificate of Need for Crisis Stabilization patients only must be accompanied by information from the SCDMH to verify this additional need, such as the number of patients currently awaiting treatment, the estimated average length of stay, the pay source for the patients, the number of patients emergently admitted to SCDMH hospitals over the past year from the area, the number of crisis patients that are expected to require this service annually, and other information to justify these additional psychiatric beds. In addition, the SCDMH will supply verification that it made contact with all hospitals in the county and contiguous counties to notify them of the potential for adding some psychiatric beds to the area. The hospital seeking the Certificate of Need will provide the necessary care for these individuals referred by the SCDMH and may be reimbursed by for the care of the patients if there are sufficient funds, but the hospital must identify the minimum number of indigent (no source of funding) patient days it will provide to patients referred by SCDMH. Should the contract with SCDMH terminate for any reason or should the hospital fail to provide care to the patients referred from the SCDMH, the license for these beds will be voided.

Based upon on-going patient analysis by DMH, consideration should be given to converting psychiatric hospital beds to other levels of care in order to accommodate the level of functioning of the patients if alternative community-based resources are not available. DMH will justify any changes in bed or service categories. Patients appropriate for de-institutionalization should be discharged when the appropriate community support services are in place.

3. William J. McCord Adolescent Treatment Facility:

The William J. McCord Adolescent Facility is a facility that has provided substance abuse treatment for adolescents statewide for a number of years. It was previously licensed as a specialized hospital with 15 substance abuse beds. Because of changes in reimbursement, McCord received a CON on

7/16/10 to convert to a specialized hospital with 15 psychiatric beds restricted primarily for the provision of alcohol and drug abuse treatments for adolescents. Although now licensed as a psychiatric hospital, the facility does not intend to change its scope of services. The bed classification change was made in order to continue receiving reimbursement. These beds will not be counted in the psychiatric bed need calculations.

CHAPTER V

REHABILITATION FACILITIES

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with impairments such as spinal cord injury, traumatic brain injury, neuromuscular diseases, hip fractures, strokes, and amputations are typical clients. CMS identified 13 specific conditions for which facilities must treat 75% of their patients in order to qualify for Medicare reimbursement; however, legislation was signed in December 2007 that would freeze this threshold at 60% and allow co-morbid conditions to be counted.

Most general hospitals and other health care facilities offer physical rehabilitation services such as physical therapy, occupational therapy, speech therapy, or occupational therapy without the involvement of a formal interdisciplinary program. In addition, some hospitals have consolidated their rehabilitation services into a single unit to improve the coordination of care for acute patients in their facilities. These consolidations are intended to improve the quality of care for patients currently being treated in the facility and are not considered to be providing comprehensive physical rehabilitation services as defined in this section of the Plan.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	2009 Occupancy
I	AnMed Health Rehab	Anderson	45	92.6% *1*
I	Roger C. Peace	Greenville	53	59.0%
I	St. Francis	Greenville	19	89.5%
I	Mary Black	Spartanburg	18	64.8%
II	Greenwood Rehab Hosp	Greenwood	34	81.8%
II	HealthSouth Columbia	Richland	96	62.0%
II	HealthSouth Rock Hill	York	46	86.5% *2*
III	HealthSouth Florence	Florence	88	56.5%
III	Carolinas Hospital	Florence	42	92.9%
III	Waccamaw Community	Georgetown	43	81.8%
IV	Beaufort Memorial	Beaufort	14	58.3%
IV	HealthSouth Charleston	Charleston	46	76.8%
IV	Roper Hospital	Charleston	52	75.8% *3*
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	70.5%
IV	Coastal Carolina Med Ctr.	Jasper	10	48.1%
		Total	630	64.9%

1 CON to convert 3 nursing home beds to rehab beds, for a total of 40 rehab beds 5/14/09, SC-09-25. CON issued for 5 additional rehab beds, for a total of 45, 7/8/09, SC-09-35. Licensed for 40 rehab beds 7/1/09.

2 CON issued 6/30/09 to add 6 rehab beds for a total of 46, SC-09-32. Licensed for 46 beds 7/9/10.

3 CON approved for 13 additional beds for a total of 52, 10/16/07, appealed. Case dismissed by ALJ Order 8/29/08. Licensed for 52 beds 10/28/09.

Certificate of Need Standards

1. The need for beds is calculated based on rehabilitation service areas.

2. The methodology takes the greater of the actual utilization of the facilities in the service area or the statewide average number of beds per 1,000 population to project need.

3. For service areas without existing rehabilitation units and related utilization data, 75% of the overall state use rate was used in the projections.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Cost Containment; and
g. Resource Availability.

Rehabilitation facilities are now located throughout the state and are available within approximately sixty (60) minutes travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

Statewide Programs

The S.C. Vocational Rehabilitation Center operates a 30-bed facility in West Columbia to serve the vocational training needs of the disabled.

REHABILITATION BED NEED

SERVICE AREA	2009 POP	2016 POP	EXIST BEDS	2009 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	253,230	271,040	45	13,010	38.15	0.70	55	10	31	-14	10
GREENVILLE,PICKENS	541,950	586,360	72	17,623	52.24	0.70	75	3	66	-6	3
CHEROKEE,SPARTANBURG UNION	364,780	387,190	18	4,260	12.39	0.70	18	0	44	26	26
CHESTER,LANCASTER YORK	288,250	313,010	46	12,636	37.59	0.70	54	8	35	-11	8
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	232,640	248,040	34	10,149	29.65	0.70	42	8	28	-6	8
FAIRFIELD,LEXINGTON NEWBERRY,RICHLAND	654,730	704,230	96	21,721	64.01	0.70	91	-5	80	-16	-5
CHESTERFIELD,DARLINGTON DILLON,FLORENCE,MARION MARLBORO,WILLIAMSBURG	377,770	387,080	130	32,384	90.91	0.70	130	0	44	-86	0
CLARENDON,KERSHAW LEE,SUMTER	228,780	242,010	0	0	0.00	0.70	0	0	27	27	27
GEORGETOWN,HORRY	295,540	332,720	43	12,839	39.60	0.70	57	14	38	-5	14
AIKEN,ALLENDALE,BAMBERG BARNWELL,CALHOUN ORANGEBURG	327,460	347,330	24	6,174	17.94	0.70	26	2	39	15	15
BEAUFORT,HAMPTON,JASPER	188,940	211,530	24	3,739	11.47	0.70	16	-8	24	0	0
BERKELEY,CHARLESTON COLLETON,DORCHESTER	647,160	688,990	98	24,316	70.93	0.70	101	3	78	-20	3
STATE TOTAL	4,401,230	4,719,530	630	158,851	464.9		665	35	534	-96	110
			0.1132								

CHAPTER VI

Alcohol and Drug Abuse Facilities

There are six types of licensed substance abuse treatment facilities in South Carolina. These are: outpatient facilities; social detoxification centers; freestanding medical detoxification facilities; residential treatment programs; inpatient treatment services, and narcotic treatment programs. These are defined as follows:

A. Outpatient Facilities:

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment, diagnosis, individual and group counseling, family counseling, case management, crisis management services, and referral. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 68 licensed "Outpatient Facilities that Treat Individuals for Psychoactive Substance Abuse or Dependence" in South Carolina, with a total of 95 locations.

Certificate of Need Standards

A Certificate of Need is not required for outpatient facilities as described above.

B. Social Detoxification Facilities:

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93.

Certificate of Need Standards

A Certificate of Need is not required for a social detoxification facility.

C. Freestanding Medical Detoxification Facilities:

A short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93. The services provided by these facilities are described in Section 3101 of the Regulation. Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities, although there are no prohibitions against an inpatient facility providing detoxification services to its clients as needed.

Morris Village, Patrick Harris, Byrnes Clinical, Holmesview and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventory of facilities.

Facility	County	Beds
Charleston Center Subacute Detoxification Program	Charleston	16
The Phoenix Center Behavioral Health Services	Greenville	16
Lexington/Richland Alcohol & Drug Abuse/Detox Unit	Richland	16
Keystone Inpatient Services	York	10
Statewide Total		58

Certificate of Need Standards

1. Medical detoxification services are allocated by service area.

2. Facilities can be licensed for a maximum of 16 beds in order to meet federal requirements.

3. Because a minimum of 10 beds is needed for a medical detoxification program, a 10 bed unit may be approved in any service area without an existing detoxification unit, provided the applicant can document the need.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Currently four freestanding medical detoxification facilities are located in the state, operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. Additional facilities are needed for the services to be accessible within sixty (60) minutes travel time for the majority of state residents. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

D. Residential Treatment Program Facilities:

RTPFs are 24-hour facilities offering an organized service in a residential setting, which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living. Residential treatment programs utilize a multi-disciplinary staff for clients whose biomedical and emotional/behavioral problems are severe enough to require residential services and who are in need of a stable and supportive environment to aid in their recovery and transition back into the community. Twenty-four hour observation, monitoring, and treatment shall be available.

Residential treatment programs provide the services described in Section 3000 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

Certificate of Need Standards

A Certificate of Need is not required for a Residential Treatment Program.

E. Inpatient Treatment Facilities:

This is a short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed, in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. Inpatient treatment facilities must comply with either Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence or Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries.

Region	Facility	County	Beds	2009 Occupancy	
I	Carolina Center Behavioral Health	Greenville	13	103.2%	
I	Holmesview Center (Statewide)	Greenville	44	71.9%	*1*
II	Self Regional Healthcare	Greenwood	24	0.0%	
II	Springs Memorial	Lancaster	~~18~~ (0)	0.0%	*2*
II	Three Rivers Behavioral Health	Lexington	17	42.7%	*3*
II	Morris Village (Statewide)	Richland	163	80.0%	*1*
II	Palmetto Health Baptist	Richland	10	0.0%	*3*
II	Palmetto Richland Springs	Richland	10	92.4%	
II	William S. Hall (Statewide)	Richland	19	80.0%	*1*
III	Carolinas Hospital System	Florence	12	44.1%	
III	Palmetto Center (Statewide)	Florence	48	71.9%	*1*
III	Lighthouse Care Center Conway	Horry	14	86.5%	*4*
IV	Aiken Regional Medical Center	Aiken	18	62.7%	
IV	Medical University	Charleston	23	39.7%	
IV	Palmetto Lowcountry Behavioral	Charleston	10	117.1%	
IV	[William J. McCord (Statewide)]	Orangeburg	(0)	93.7%	*5*
	Total (Does Not Include Statewide Beds)		151	48.0%	

1 Not Included in Bed Need Calculations.

2 CON approved 8/22/08 to convert the 18 substance abuse beds to general beds, appealed.

3 CONs issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psych beds from Palmetto Baptist. Beds licensed at Baptist and de-licensed at Three Rivers 7/21/08.

4 CON issued 1/25/10 for 6 additional beds for a total of 14.

5 CON issued 7/16/10 to re-classify William J. McCord Adolescent Treatment Facility as a specialized hospital with 15 psychiatric beds restricted for the primary purpose of providing alcohol and drug services to adolescents. These beds are no longer classified as inpatient substance abuse treatment beds.

Morris Village, Holmesview, Palmetto Center and William S. Hall are classified as statewide facilities with restricted admissions procedures and are not included in the inventory of facilities and need calculations.

Certificate of Need Standards

1. Need projections are calculated by service area.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide beds per 1,000 population to project need.

3. For service areas without existing psychiatric units and related utilization data, the state use rate was used in the projections.

4. Because a minimum of 10 beds is needed for an inpatient program, a 10-bed unit may be approved in an area that does not have any existing beds provided the applicant can document the need.

5. Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to its clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.

6. The establishment of a regional treatment center that serves more than a single service area may be proposed in order to improve access to care for patients in service areas that do not currently have such services available. Such a proposed center would be allowed to combine the bed need for a service area without existing services with another service area providing this other service area shows a need for additional beds. The applicant must document with patient origin data the historical utilization of the residents in the service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to used to form a regional treatment facility.

7. It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology to their illnesses. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the Department will allow deviations of up to 25% of the total number of licensed beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Distribution (Accessibility);

INPATIENT BED NEED

SERVICE AREA	2009 POP	2016 POP	EXIST BEDS	2009 PAT DAYS	PROJ ADC	% OCCUP	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	205,010	222,050	0	0	0.00	0.70	0	0	8	8	8
GREENVILLE,PICKENS	438,400	479,830	13	4,896	14.68	0.70	21	8	18	5	8
CHEROKEE,SPARTANBURG,UNION	292,190	313,420	0	0	10.37	0.70	15	15	12	12	15
CHESTER,LANCASTER,YORK	231,600	255,290	0	0	0.00	0.70	0	0	10	10	10
ABBEVILLE,EDGEFIELD,GREENWOOD, LAURENS,MCCORMICK,SALUDA	188,780	204,050	24	0	6.75	0.70	10	-14	8	-16	-14
FAIRFIELD,KERSHAW,LEXINGTON, NEWBERRY,RICHLAND	575,950	625,610	37	6,874	20.46	0.70	29	-8	24	-13	-8
DARLINGTON,FLORENCE,MARION	190,340	199,010	12	1,931	5.53	0.70	8	-4	8	-4	-4
CHESTERFIELD,DILLON,MARLBORO	80,270	81,390	0	0	2.69	0.70	4	4	3	3	4
CLARENDON,LEE,SUMTER	134,410	141,490	0	0	4.68	0.70	7	7	5	5	7
GEORGETOWN,HORRY,WILLIAMSBURG	278,560	315,600	14	2,526	10.44	0.70	15	1	12	-2	1
BAMBERG,CALHOUN,ORANGEBURG	103,440	107,510	0	0	3.56	0.70	5	5	4	4	5
ALLENDALE,BEAUFORT,HAMPTON, JASPER	167,240	190,820	0	0	6.31	0.70	9	9	7	7	9
BERKELEY,CHARLESTON,COLLETON DORCHESTER	522,110	557,410	33	7,604	22.24	0.70	32	-1	21	-12	-1
AIKEN,BARNWELL	151,610	166,670	18	4,121	12.41	0.70	18	0	6	-12	0
STATE TOTAL	3,559,910	3,860,150	151	27,952	120.12		173	22	147	-4	40
	0.012074		0.0391								

3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Currently, 11 inpatient treatment facilities are located in the state, not including state-operated facilities. There is a projected need for additional beds in some service areas. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

F. Narcotic Treatment Programs:

Narcotic treatment programs were removed from Certificate of Need review by the General Assembly in 2010.

CHAPTER VII

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS

A Residential Treatment Facility for Children and Adolescents is operated for the assessment, diagnosis, treatment, and care of children and adolescents in need of mental health treatment. This means a child or adolescent up to age 21 who manifests a substantial disorder of cognitive or emotional process, which lessens or impairs to a marked degree that child's capacity either to develop or to exercise age-appropriate or age-adequate behavior. The behavior includes, but is not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgment, including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others.

These facilities provide medium to long-term care (6 months or longer). Treatment modalities are both medical and behavioral in nature. Some facilities contract with the Continuum of Care for Emotionally Disturbed Children to provide these services. The following facilities are currently licensed or approved as Residential Treatment Facilities:

Region	Facility	County	Beds	FY 2009 Occ. Rate	
I	Excalibur Youth Services	Greenville	60	47.9%	*1*
I	Generations – Bridges	Greenville	(10)	---	*2*
I	Generations – Horizons	Greenville	(20)	---	*2*
I	Marshall Pickens	Greenville	22	89.1%	
I	Springbrook Behavioral	Greenville	68	80.2%	
I	Avalonia Group Homes	Pickens	55	55.8%	*3*
II	Three Rivers Behavioral	Lexington	20	89.0%	
II	Three Rivers – Midlands	Lexington	59	94.0%	
II	Carolina Children's Home	Richland	20 (30)	47.3%	*4*
II	Directions (DMH)	Richland	37	52.6%	
II	New Hope Carolinas	York	150	83.9%	*5*
II	York Place Episcopal	York	40	72.3%	
III	Palmetto Pee Dee	Florence	59	95.1%	
III	Lighthouse of Conway	Horry	30	85.6%	*6*
III	Willowglen Academy	Williamsburg	40 (54)	43.0%	*7*
IV	Palmetto Low Country	Charleston	32	95.3%	
IV	Riverside at Windwood	Charleston	12	---	*8*
IV	Palmetto Pines Behavioral	Dorchester	60	92.0%	
IV	Pinelands RTC	Dorchester	14 (28)	---	*9*
	Total (Does Not Include Directions)		741 (809)	78.8%	

1 Licensed for 42 beds 12/31/08. CON issued 3/26/09 to add 18 beds for a total of 60, SC-09-15; licensed for 60 beds 6/26/09.

2 Exempted to convert from a Group Home to an RTF.
3 Licensed 9/18/08.
4 Licensed for 20 RTF beds 6/16/09; intend to license 30 total beds.
5 Licensed 11/20/08.
6 Number of licensed RTF beds increased from 16 to 30, 10/29/09.
7 Licensed for 40 beds 3/20/09; intend to license 54 total beds.
8 Licensed 3/18/10.
9 Licensed for 14 beds 7/21/10; intend to license 28 total beds.

Services available at a minimum should include the following:

1. 24-hour, awake supervision in a secure facility;

2. Individual treatment plans to assess the problems and determine specific patient goals;

3. Psychiatric consultation and professional psychological services for treatment supervision and consultation;

4. Nursing services, as required;

5. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;

6. Recreational facilities with an organized youth development program;

7. A special education program with a minimum program defined by the South Carolina Department of Education; and

8. Discharge planning including a final assessment of the patient's condition and an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

Each facility shall have a written plan for cooperation with other public and private organizations, such as schools, social service agencies, etc., to ensure that each child under its care will receive comprehensive treatment. In addition, each facility shall have a written transfer agreement with one or more hospitals for the transfer of emergency cases when such hospitalization becomes necessary.

A proposal for Residential Treatment Facilities for Children and Adolescents should have letters of support from the Continuum of Care for Emotionally Disturbed Children, the SC Department of Social Services and the SC Department of Mental Health. Priority consideration will be given to those facilities that propose to serve highly aggressive and sexual offending youths and those with other needs as determined by these State agencies. In addition, smaller facilities may be given greater consideration than large facilities based on recommendations from the above agencies.

Certificate of Need Standards

1. Except in the case of high management group homes that received exemption from CON through Health and Human Services Budget Proviso 8.35, the establishment or expansion of an RTF requires a CON.

2. The applicant must document the need for the expansion of or the addition of an RTF based on the most current utilization data available. The existing resources must be considered and documentation presented as to why these resources are not adequate to meet the needs of the community.

3. For a new facility, the applicant must document where the potential patients for the facility will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

4. The applicant must document the potential impact that the proposed new RTF or expansion will have upon the existing service providers and referral patterns.

5. The applicant must provide a written commitment that the facility will provide services for indigent and charity patients at a percentage that is comparable to other health care facilities in the service area.

6. The applicant agrees to provide utilization data on the operation of the facility to the Department.

The bed need methodology to be used in South Carolina is based upon a standard of 41.4 beds per 100,000 children. Since few, if any, children under 6 years of age would be candidates for this type of care, the bed need will be based on the population age 6-21. The projected bed needs by service area are as follows:

Inventory Region I (Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, Union).

Facilities:	Avalonia Group Homes	55 beds
	Excalibur Youth Services	60
	Generations – Bridges	10
	Generations – Horizons	20
	Marshall Pickens	22
	Springbrook Behavioral	68
	Total	235 beds

2016 Population Age 6-21:	267,200
41.4 Beds/100,000 Population:	x .000414
	110 beds
	- 235 beds
Need Shown:	(115) beds

Inventory Region II Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda, York.

Facilities:		
	Carolina Children's Home	30 beds
	New Hope Carolinas	150
	Three Rivers Behavioral	20
	Three Rivers – Midlands	59
	York Place	40
	Total	299 beds

2016 Population Age 6-21:	287,150
41.4 Beds/100,000 Population:	x .000414
	119 beds
	- 299 beds
Need Shown:	(180) beds

Inventory Region III Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg.

Facilities:		
	Lighthouse of Conway	30 beds
	Palmetto Pee Dee	59
	Willowglen Academy	54
	Total	143 beds

2016 Population Age 6-21:	176,440
41.4 Beds/100,000 Population:	x .000414
	119 beds
	- 143 beds
Need Shown:	(24) beds

Inventory Region IV	Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg.	
Facilities:	Palmetto Low Country	32 beds
	Palmetto Pines Behavioral	60
	Pinelands RTC	28
	Riverside at Windwood	12
	Total	132 beds

2016 Population Age 6-21:	247,360	
41.4 Beds/100,000 Population:	x .000414	
	103	beds
	- 132	beds
Need Shown:	(29)	beds

The Directions program primarily serves court-ordered patients from the Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it is not included in the regional inventories for bed need calculations.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Projected Revenues;
d. Projected Expenses;
e. Record of the Applicant;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Residential treatment facility beds for children and adolescents are distributed statewide and are located within sixty (60) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER VIII

CARDIOVASCULAR CARE

Cardiovascular diseases are the leading cause of death in the United States, accounting for more than 40% of all deaths. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country. Approximately one-third of all heart attacks are fatal. The amount of heart muscle damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive.

Diagnostic and therapeutic cardiac catheterizations and open heart surgery are tools in the treatment of heart disease. During a cardiac catheterization, a thin, flexible tube is inserted into a blood vessel in the arm or leg. The physician manipulates the tube to the chambers or vessels of the heart so that pressure measurements, blood samples and photographs can be taken. Injections of contrast material allow blockages or areas of weakness to appear on x-rays. Other diagnostic and therapeutic procedures may also be performed. Diagnostic catheterizations take approximately one and one-half hours to perform, while therapeutic catheterizations average three hours.

Percutaneous Coronary Intervention (PCI) is a therapeutic catheterization procedure used to treat occluded or partially occluded coronary arteries. A catheter with a balloon (PTCA) or a stent is inserted into the blood vessel and guided to the site of the constriction in the vessel. Due to the risk of arterial damage and the resulting need for immediate open heart surgery, elective PCI is contraindicated for institutions without an on-site open heart surgery program. Hospitals without an open heart surgery program shall be allowed to provide Emergent PCIs (Primary PCIs) only if they comply with all sections of Standard (8) of the Standards for Cardiac Catheterization.

During a Percutaneous Transluminal Coronary Angioplasty (PTCA), a balloon is inflated to flatten plaque against the artery wall and widen the narrowed artery. When a stent is used, an expandable metal coil is implanted at the site of a narrowing in a coronary artery to keep the vessel open; the framework buttresses the wall of the coronary artery. Newer drug-eluting stents are coated with an anti-rejection drug. It is anticipated that the increased use of stents may reduce the number of open heart surgeries performed.

Open heart surgery or cardiac surgery refers to an operation performed on the heart or intrathoracic great vessels. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases, where veins are extracted from the patient and grafted to bypass a constricted section of coronary artery. The thoracic cavity is opened to expose the heart, which is stopped and the blood is recirculated and oxygenated during surgery by a heart-lung machine. Another option is "beating heart surgery," like Minimally Invasive Direct Coronary Artery Bypass (MIDCAB), where the surgeon operates through a smaller incision rather than breaking the breastbone to open the chest cavity and no bypass machine is used. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. The mortality rate continues to decline, but CABG still carries significant risks.

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs may reflect unnecessary duplication of services in an area, which may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of 600 diagnostic equivalents per year (diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0). Emergent PCI providers should perform a minimum of 36 PCIs annually; all other therapeutic cath providers should perform a minimum of 300 therapeutic caths annually. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, biopsies performed after heart transplants as 1.0 equivalents, and adult concomitant congenital heart disease procedures performed in these labs are included in the utilization calculations. A minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to appear in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year, at least 75 of which should be open heart surgery.

A. Status of South Carolina Providers:

1. Cardiac Catheterizations:

The Certificate of Need standards for cardiac catheterization require a minimum of 600 cardiac equivalents per laboratory annually within 3 years of initiation of service. There are 32 facilities approved to provide cardiac catheterization services in fixed laboratories in South Carolina. Of the 30 facilities that have been offering cardiac caths for more than three years, 19 exceeded the minimum of 600 equivalents per lab in 2009. Baptist Easley Hospital, Beaufort Memorial, Bon Secours St. Francis Xavier, Carolina Pines, Conway Hospital, Loris Community Hospital, Mary Black Memorial, Palmetto Health Baptist, Regional Medical Center–Orangeburg/Calhoun, Springs Memorial, and Tuomey Hospital fell below the minimum. Kershaw County Medical Center was not fully operational for 3 years and Village Hospital was approved for a diagnostic cath lab in November 2010. There are two mobile cath labs approved in the state, at Colleton Medical Center and Chester Regional Medical Center. The number of diagnostic catheterizations performed statewide increased from 37,495 in 2008 to 37,813 in 2009.

Seventeen hospitals with open heart surgery programs provide therapeutic caths. They should be performing a minimum of 300 therapeutic caths annually within three years of initiation of service. Of the programs that had been operational for three full years, all but Aiken Regional Medical Center and Hilton Head Regional Medical Center performed the minimum number in 2009. In addition, Baptist Easley Hospital and Georgetown Memorial Hospital have received CONs to perform Emergent PCIs without open heart surgery back-up. Lexington Medical Center received a CON to perform Emergent PCIs without open heart surgery back-up in 2009, but then established comprehensive cath services through the transfer of an open heart surgery suite from Providence

Hospital in 2010. The number of therapeutic catheterizations performed statewide increased from 15,716 in 2008 to 15,903 in 2009.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The standard recommends a minimum of 600 cardiac equivalents per year; MUSC performed 1,234 equivalents in 2009.

2. Open Heart Surgery:

Currently 17 open heart surgery programs have been approved for the general public in South Carolina, in addition to the Veterans Administration (VA) Hospital in Charleston. Lexington Medical Center received a CON on 6/18/10 to establish open heart surgery services through the relocation of one open heart surgery suite from Providence Hospital. The number of open heart surgeries performed decreased from 5,219 in 2008 to 5,053 in 2009. A total of 35 open heart surgery suites were in operation in 2009. With a capacity of 500 surgeries per suite, the statewide capacity was 17,500 surgeries. The state average utilization rate of 28.9% equated to 144.5 surgeries per suite. Unused capacity remains in all programs in the state.

The Certificate of Need standard is for a facility to perform a minimum of 200 open heart surgeries per year per surgical suite within three years of initiation of service. Only Spartanburg Regional, Palmetto Health Richland, Providence Hospital, Roper Hospital, and Trident Medical Center averaged at least 200 open heart surgeries per suite in 2009. Studies indicate that hospitals that perform a minimum of 350 total cases annually tend to have better outcomes than those that perform fewer cases. In 2009, only eight of the 16 existing programs performed more than 350 total surgeries.

MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 2009, 209 pediatric open heart surgeries were performed there.

The Certificate of Need standards for Cardiac Catheterization and Open Heart Surgery follow.

B. Cardiac Catheterization:

1. Definitions:

"Cardiac Catheterization Procedure" is an invasive procedure where a thin, flexible catheter is inserted into a blood vessel; the physician then manipulates the free end of the catheter into the chambers or vessels of the heart. All activities performed during one clinical session, including angiocardiography, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies shall be considered one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed. They are located only in hospitals approved to provide open heart surgery, although diagnostic laboratories are allowed to perform emergency therapeutic catheterizations in compliance with Standard 8 below.

"Diagnostic Catheterization" refers to a cardiac catheterization during which any or all of the following diagnostic procedures or measures are performed: Blood Pressure; Oxygen Content and Flow Measurements; Angiocardiography, Coronary Arteriography; and Pulmonary Arteriography. The following ICD-9-CM Procedure Codes refer to diagnostic catheterizations:

37.21 Right Heart Cardiac Catheterization
37.22 Left Heart Cardiac Catheterization
37.23 Combined Right and Left Heart Cardiac Catheterization

"Diagnostic Catheterization Laboratory" means a dedicated room in which only diagnostic catheterizations are performed.

"Diagnostic Equivalents" are the measurements of capacity and utilization for cardiac catheterization laboratories. For adult labs, diagnostic catheterizations are weighted as 1.0 equivalents and therapeutic caths are weighted as 2.0 equivalents. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, and biopsies performed after heart transplants as 1.0 equivalents.

"Percutaneous Coronary Intervention (PCI)" refers to a therapeutic procedure to relieve coronary narrowing, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Stent Implantation.

"Therapeutic catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants and Cardiac Valvuloplasty. The following ICD-9-CM Procedure Codes refer to therapeutic catheterizations:

00.66 Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy
35.52 Repair of Atrial Septal Defect with Prothesis, Closed Technique

35.96 Percutaneous Valvuloplasty
36.06 Insertion of Coronary Artery Stent(s)
36.07 Insertion of Drug Eluting Coronary Artery Stent(s)
36.09 Other Removal of Coronary Artery Obstruction
37.34 Excision or Destruction of Other Lesion or Tissue of Heart, Other Approach

2. Scope of Services:

The following services should be available in both adult and pediatric catheterization laboratories:

A. Each cardiac catheterization lab should be competent to provide a range of angiographic (angiocardiography, coronary arteriography, pulmonary arteriography), hemodynamic, and physiologic (cardiac output measurement, intracardiac pressure, etc.) studies. These facilities should be available in one laboratory so that the patient need not be moved during a procedure.

B. The lab should have the capability of immediate endocardiac catheter pacemaking in cardiac arrest, a crash cart, and defibrillator.

C. A full range of non-invasive cardiac/circulatory diagnostic support services, such as the following, should be available within the hospital:

1. Nuclear Cardiology
2. Echocardiography
3. Pulmonary Function Testing
4. Exercise Testing
5. Electrocardiography
6. Cardiac Chest X-ray and Cardiac Fluoroscopy
7. Clinical Pathology and Blood Chemistry Analysis
8. Phonocardiography
9. Coronary Care Units (CCUs)
10. Medical Telemetry/Progressive Care

D. Each applicant shall document plans for providing cardiac rehabilitation services to its patients or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Cardiac catheterization studies for elective cases should be available at least 40 hours a week. All catheterization laboratories should have the capacity for rapid mobilization of the study team for emergency procedures 24 hours a day, 7 days a week. All facilities offering cardiac catheterization services should meet full accreditation standards for The Joint Commission (TJC) or similar accrediting body.

Certificate of Need Standards

1. The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Adult diagnostic catheterizations (ICD-9-CM Procedure Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Procedure Codes 00.66, 35.52, 35.96, 36.06, 36.07, 36.09, and 37.34) shall be weighted as 2.0 equivalents. For pediatric and adult congenital cath labs, diagnostic caths shall be weighted as 2.0 equivalents, therapeutic caths shall be weighted as 3.0 equivalents, electrophysiology (EP) studies shall be weighted as 2.0 equivalents, and biopsies performed after heart transplants shall be weighted as 1.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

2. The service area for a diagnostic catheterization laboratory is defined as all facilities within 45 minutes one way automobile travel time; for comprehensive cardiac catheterization laboratories the service area is all facilities within 60 minutes one way automobile travel time; a pediatric cardiac program should serve a population encompassing at least 30,000 births per year, or roughly two million people.

3. New diagnostic cardiac catheterization services, including mobile services, shall be approved only if all existing labs in the service area have performed at a combined use rate of 80% (960 equivalents per laboratory) for the most recent year;

4. An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity.

5. An applicant for a mobile diagnostic catheterization laboratory must be able to project a minimum of 120 diagnostic equivalents annually for each day of the week that the mobile lab is located at the applicant's facility by the end of the third year following initiation of the service, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity (i.e. an applicant wishing to have a mobile cath lab 2 days per week must project a minimum of 240 equivalents at the applicant's facility by the end of the third year of operation). In addition:

   A. The applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 600 diagnostic equivalents per year;

   B. The applicant must include vendor documentation of the complication rate of the mobile units operated by the vendor; and

   C. If an application for a mobile lab is approved and the applicant subsequently desires to change vendors, the Department must approve such change in order to insure that appropriate minimum utilization can be documented.

6. Expansion of an existing diagnostic cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e. 960 equivalents per laboratory) for each of the past two years and can project a minimum of 600 procedures per year on the additional equipment within three years of its implementation.

7. Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PCI and other therapeutic procedures, shall only be located in hospitals that provide open heart surgery. The ACC/AHA/SCAI Writing Committee continues to support the recommendation that elective PCI should not be performed in facilities without on-site cardiac surgery, due to the risk of arterial damage and subsequent need for emergency bypass surgery. Diagnostic cardiac catheterization laboratories, which serve to detect and identify defects in the great arteries or veins of the heart or abnormalities in the heart structure, shall be allowed to perform emergency PCI provided they comply with all sections of standard 8.

8. The provision of emergency PCI (Primary PCI) at a hospital without an on-site comprehensive catheterization laboratory and an open heart surgery program requires a Certificate of Need. This application shall be approved only if all of the following criteria are met:

   A. Therapeutic catheterizations must be limited to Percutaneous Coronary Interventions (PCIs) performed only in emergent circumstances (Primary PCIs). Elective PCI may not be performed at institutions that do not provide on-site cardiac surgery.

   B. The applicant has a diagnostic catheterization laboratory that has performed a minimum of 600 diagnostic catheterizations for the most recent year of data.

   C. The hospital must acquire an intra-aortic balloon pump (IABP) dedicated solely to this purpose.

   D. The chief executive officer of the hospital must sign an affidavit assuring that the criteria listed below are and will continue to be met at all times.

   E. An application shall be approved only if it is consistent with the criteria from *Smith et al., ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)* and the *2007 Focused Update* of the guidelines. The complete guidelines can be found at: www.acc.org/clinical/guidelines/percutaneous/update/index.pdf

      1. Criteria for the Performance of Emergency (Primary) PCI

a. The physicians must be experienced interventionalists who regularly perform elective intervention at a surgical center (75 cases/year). The institution must perform a minimum of 36 primary PCI procedures per year.

b. The nursing and technical catheterization laboratory staff must be experienced in handling acutely ill patients and comfortable with interventional equipment. They must have acquired experience in dedicated interventional laboratories at a surgical center. They participate in a 24-hour, 365-day call schedule.

c. The catheterization laboratory itself must be well-equipped, with optimal imaging systems, resuscitative equipment, intra-aortic balloon pump (IABP) support, and must be well-stocked with a broad array of interventional equipment.

d. The cardiac care unit nurses must be adept in hemodynamic monitoring and IABP management.

e. The hospital administration must fully support the program and enable the fulfillment of the above institutional requirements.

f. There must be formalized written protocols in place for immediate (within one hour) and efficient transfer of patients to the nearest cardiac surgical facility that are reviewed/tested on a regular (quarterly) basis.

g. Primary (emergency) intervention must be performed routinely as the treatment of choice around the clock for a large proportion of patients with acute myocardial infarction (AMI) to ensure streamlined care paths and increased case volumes.

h. Case selection for the performance of primary (emergency) angioplasty must be rigorous. Criteria for the types of lesions appropriate for primary (emergency) angioplasty and for the selection for transfer for emergent aortocoronary bypass surgery are shown in Section E.2.

i. There must be an ongoing program of outcomes analysis and formalized periodic case review. Institutions should participate in a three-to-six month period of implementation during which time development of a formalized primary PCI program is instituted that includes establishing standards, training staff, detailed logistic development, and creation of a quality assessment and error management system.

2. Patient Selection Guidelines

   a. Avoid intervention in hemodynamically stable patients with:

1) Significant (60%) stenosis of an unprotected left main (LM) coronary artery upstream from an acute occlusion in the left coronary system that might be disrupted by the angioplasty catheter.
2) Extremely long or angulated infarct-related lesions with TIMI grade 3 flow.
3) Infarct-related lesions with TIMI grade 3 flow in stable patients with 3-vessel disease.
4) Infarct-related lesions of small or secondary vessels.
5) Lesions in other than the infarct artery.

b. Transfer emergent aortocoronary bypass surgery patients after PCI of occluded vessels if high-grade residual left main or multi-vessel coronary disease and clinical or hemodynamic instability are present, preferably with intra-aortic balloon pump support

9. New comprehensive cardiac catheterization services shall be approved only if the following conditions are met:

A. All existing comprehensive cardiac catheterization facilities in the service area performed a minimum of 300 therapeutic catheterizations and performed at a combined use rate of 80 percent in the most recent year (i.e. 960 equivalents per laboratory); and

B. An applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the combined use rate of the existing comprehensive catheterization programs in the service area below 80%.

10. Expansion of an existing comprehensive cardiac catheterization service shall be approved only if the service has operated at a minimum use rate of 80% of capacity (960 equivalents per lab) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation. The 600 equivalents may consist of a combination of diagnostic and therapeutic procedures.

11. New pediatric cardiac catheterization services shall be approved only if the following conditions are met:

A. All existing facilities have performed at a combined use rate of 80% of capacity for the most recent year; and

B. An applicant must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services.

12. Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation.

13. Documentation of need for the proposed service:

    A. The applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which diagnostic, comprehensive or pediatric catheterization is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

    B. The applicant shall project the utilization of the service and the effect of its projected utilization on other cardiac catheterization services within its service area, to include:

        1. The number of patients of the applicant hospital who were referred to other cardiac catheterization services in the preceding three years and the number of those patients who could have been served by the proposed service;

        2. The number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

        3. Existing and projected patient origin information and referral patterns for each cardiac catheterization service serving patients from the area proposed to be served shall be provided.

14. Both fixed and mobile diagnostic cardiac catheterization laboratories must provide a written agreement with at least one hospital providing open heart surgery, which states specified arrangements for referral and transfer of patients, to include:

    A. Criteria for referral of patients on both a routine and an emergency back-up basis;

    B. Regular communications between cardiologists performing catheterizations and surgeons to whom patients are referred;

    C. Acceptability of diagnostic results from the cardiac catheterization service to the receiving surgical service to the greatest extent possible to prevent duplication of services; and

    D. Development of linkages with the receiving institution's peer review mechanism.

15. The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the

American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk. For diagnostic catheterization laboratories, this description of patient selection criteria shall include referral arrangements for high-risk patients. For comprehensive laboratories, these high-risk procedures should only be performed with open heart surgery back-up. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

16. Cardiac catheterization services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform diagnostic, therapeutic and/or pediatric catheterizations. In addition, standards should be established to assure that each physician using the service would be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

17. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

No ideal rate has been established for PTCA [PCI] and the rates vary widely by area and population group. The IQI considers PCI to be a potentially over-used procedure and a more average rate equates to better quality care. However, high PCI utilization has not been shown to necessarily be associated with higher rates of inappropriate utilization. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

Every minute saved is important in treating heart attacks. According to guidelines established by the ACC/AHA in 2004, facilities that provide primary PCI for acute MI patients should initiate the PCI within 90 minutes from the time of hospital arrival. The ACC created the D2B Alliance in 2006 to advise hospitals on how to reduce the door-to-balloon time. The national rate has improved from approximately 50% in 2005 to nearly 90% as of December 2009. For the first quarter of 2009, the state average was 89.93%. For the hospitals for which data were available, Greenville Memorial had the highest rate (99.3%) and Piedmont Medical Center had the lowest rate (81.0%). Source: http://whynotthebest.org/reports/view

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;

c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Staff Resources; and
i. Adverse Effects on Other Facilities.

The Department finds that:

(1) Diagnostic catheterization services are available within forty-five (45) minutes and therapeutic catheterization services within ninety (90) minutes travel time for the majority of South Carolina residents;

(2) Significant cardiac catheterization capacity exists in most areas of the State; and

(3) The preponderance of the literature on the subject indicates that a minimum number of procedures are recommended per year in order to develop and maintain physician and staff competency in performing these procedures.

The benefits of improved accessibility will not outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CARDIAC CATHETERIZATION PROCEDURES

REGION/FACILITY	# CATH LABS	FY07 ADULT DIAG	FY07 ADULT THERP	FY07 ADULT TOTAL	FY07 PED DIAG	FY07 PED THERP	FY07 PED TOTAL	FY08 ADULT DIAG	FY08 ADULT THERP	FY08 ADULT TOTAL	FY08 PED DIAG	FY08 PED THERP	FY08 PED OTHER	FY08 PED TOTAL	FY09 ADULT DIAG	FY09 ADULT THERP	FY09 ADULT TOTAL	FY09 PED DIAG	FY09 PED THERP	FY09 PED OTHER	FY09 PED TOTAL
I																					
ANMED HEALTH MEDICAL CENTER *1*	4	1,971	1,305	3,276				1,993	1,222	3,215					1,907	1,301	3,208				
GREENVILLE MEMORIAL HOSPITAL	7	2,118	3,373	5,491				3,163	2,467	5,630					2,858	2,302	5,160				
SAINT FRANCIS - DOWNTOWN *2*	4	1,471	762	2,233				1,906	1,052	2,958					2,077	1,401	3,478				
OCONEE MEMORIAL HOSPITAL	1	700		700				882		882					776		776				
BAPTIST MED CTR-EASLEY *3*	1	497		497				474		474					400		400				
MARY BLACK MEMORIAL	1	212		212				154		154					150		150				
SPARTANBURG REGIONAL MEDICAL CTR	4	3,217	1,013	4,230				2,283	1,011	3,294					2,299	964	3,263				
VILLAGE HOSPITAL *4*	1																				
TOTAL REGION I	23	10,186	6,453	16,639				10,855	5,752	16,607					10,467	5,968	16,435				
II																					
CHESTER REGIONAL MEDICAL CENTER	MOBILE	118		118				116		116					95		95				
SELF REGIONAL HEALTHCARE	2	1,151	323	1,474				1,324	408	1,732					1,137	396	1,533				
KERSHAWHEALTH	1			0				367		367					507		507				
SPRINGS MEMORIAL HOSPITAL	1	320		320				544		544					567		567				
LEXINGTON MEDICAL CENTER *5*	2	1,253	12	1,265				1,128	3	1,131					1,242	16	1,258				
PALMETTO HEALTH BAPTIST	1	269		269				275		275					293		293				
PALMETTO HEALTH RICHLAND	4	3,197	1,157	4,354				3,208	1,170	4,378					3,338	1,245	4,583				
PROVIDENCE HOSPITAL	6	3,583	2,723	6,306				3,460	2,700	6,160					3,474	2,700	6,174				
PIEDMONT MEDICAL CENTER	3	1,521	798	2,319				1,595	864	2,459					1,422	759	2,181				
SOUTH CAROLINA HEART CENTER *6*	2	2,172		2,172				1,829		1,829					1,750		1,750				
TOTAL REGION II	23	13,584	5,013	18,597				13,846	5,145	18,991					13,825	5,116	18,941				
III																					
CAROLINA PINES REGIONAL MEDICAL CTR	1	146		146				61		61					62		62				
CAROLINAS HOSPITAL SYSTEM	2	1,082	246	1,328				1,155	263	1,418					2,406	547	2953				
MCLEOD REGIONAL MEDICAL CENTER	4	1,859	776	2,635				1,823	760	2,583					1,504	595	2099				
GEORGETOWN MEMORIAL HOSPITAL	1	951	58	1,009				868	59	927					611	63	674				
CONWAY HOSPITAL	1	765		765				557		557					585		585				
GRAND STRAND REGIONAL MED CTR *7*	3	1,177	524	1,701				862	580	1,442					1,057	667	1724				
LORIS COMMUNITY HOSPITAL	1	301		301				238		238					247		247				
TUOMEY	1	311		311				307		307					281		281				
TOTAL REGION III	14	6,592	1,604	8,196				5,871	1,662	7,533					6,753	1,872	8,625				
IV																					
AIKEN REGIONAL MEDICAL CENTER	1	710	511	1,221				608	500	1,108					519	243	762				
BEAUFORT MEMORIAL HOSPITAL	1	485		485				386		386					482		482				
HILTON HEAD HOSPITAL	2	685	227	912				624	235	859					478	240	718				
COLLETON MEDICAL CENTER	MOBILE														0		0				
BON SECOURS ST. FRANCIS XAVIER	1														0		0				
MUSC MEDICAL CENTER	5	1,617	1,334	2,951	215	119	334	1,435	1,038	2,473	232	217	93	542	1,517	1,184	2,701	252	241	741	1,234
ROPER HOSPITAL	3	1,898	942	2,840				1,979	992	2,971					1,943	910	2,853				
TRIDENT MEDICAL CENTER	2	1,456	372	1,828				1,417	392	1,809					1,429	370	1,799				
REG MED CTR ORANGEBURG-CALHOUN	1	455		455				474		474					400		400				
RALPH HENRY VA MED CTR CHARLESTON	(1)	(440)	(302)	(742)																	
TOTAL REGION IV	17	7,306	3,386	10,692	215	119	334	6,923	3,157	10,080	232	217	93	542	6,768	2,947	9,715	252	241	741	1,234
STATEWIDE TOTALS	**77**	**37,668**	**16,456**	**54,124**	**215**	**119**	**334**	**37,495**	**15,716**	**53,211**	**232**	**217**	**93**	**542**	**37,813**	**15,903**	**53,716**	**252**	**241**	**741**	**1,234**

1 CON ISSUED 5/14/09 FOR A 4TH CATH LAB, SC-09-24.
2 CON ISSUED 7/8/09 FOR A 4TH CATH LAB, SC-09-34; OPERATIONAL 12/30/09.
3 CON ISSUED 6/2/06 TO ALLOW EMERGENT PCI.
4 CON APPROVED 11/5/10 FOR A DIAGNOSTIC LAB
5 CON ISSUED 5/12/09 TO ADD 2ND LAB & ALLOW EMERGENT PCI, SC-09-23. CON ISSUED 6/18/10 TO ESTABLISH COMPREHENSIVE CATH SERVICES THROUGH TRANSFER OF AN OPEN HEART SUITE FROM PROVIDENCE HOSPITAL, SC-10-19.
6 DOCTORS OFFICE.
7 CON ISSUED 3/14/07 FOR A 3RD CATH LAB, SC-07-10.

C. Open Heart Surgery:

1. Definitions:

"Capacity" means the number of open heart surgery procedures that can be accommodated in an open heart surgery unit in one year.

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels. It is identified by the following ICD-9-CM procedure codes: 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.41-35.42, 35.50-35.51, 35.53-35.54, 35.60- 35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 36.03, 36.09, 36.10-36.16, 36.19, 36.2, 36.91, 36.99, 37.10-37.11, 37.32-37.33.

An "Open Heart Surgery Unit" is an operating room or suite of rooms equipped and staffed to perform open heart surgery procedures; such designation does not preclude its use for other related surgeries, such as vascular surgical procedures. A hospital with an open heart surgery program may have one or more open heart surgery units.

"Open Heart Surgical Procedure" means an operation performed on the heart or intrathoracic great vessels within an open heart surgical unit. All activities performed during one clinical session shall be considered one procedure.

"Open Heart Surgical Program" means the combination of staff, equipment, physical space and support services which is used to perform open heart surgery. Adult open heart surgical programs should have the capacity to perform a full range of procedures, including:

1. repair/replacement of heart valves
2. repair of congenital defects
3. cardiac revascularization
4. repair/reconstruction of intrathoracic vessels
5. treatment of cardiac traumas.

In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon and prolonged cardiopulmonary partial bypass.

2. Scope of Services:

A range of non-invasive cardiac and circulatory diagnostic services should be available within the hospital, including the following:

a. services for hematology and coagulation disorders;
b. electrocardiography, including exercise stress testing;
c. diagnostic radiology;
d. clinical pathology services which include blood chemistry and blood gas analysis;

e. nuclear medicine services which include nuclear cardiology;
f. echocardiography;
g. pulmonary function testing;
h. microbiology studies;
i. Coronary Care Units (CCU's);
j. medical telemetry/progressive care; and
k. perfusion.

Backup physician personnel in the following specialties should be available in emergency situations:

a. Cardiology;
b. Anesthesiology;
c. Pathology;
d. Thoracic Surgery; and
e. Radiology.

Each applicant shall document plans for providing cardiac rehabilitation services to its patients or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Adult open heart surgery services should be available within 60 minutes one-way automobile travel for 90% of the population. A pediatric cardiac surgical service should provide services for a minimum service area population with 30,000 live births, or roughly 2 million people. Open heart surgery for elective procedures should be available at least 40 hours per week, and elective open heart surgery should be accessible with a waiting time of no more than two weeks. All facilities providing open heart surgery must conform with local, state, and federal regulatory requirements and should meet the full accreditation standards for The Joint Commission (TJC), if the facility is TJC accredited.

Certificate of Need Standards

1. The establishment or addition of an open heart surgery unit requires Certificate of Need review, as this is considered a substantial expansion of a health service.

2. Comprehensive cardiac catheterization laboratories shall only be located in hospitals that provide open heart surgery. The lack of a formal cardiac surgical program within the institution is an absolute contraindication for therapeutic catheterizations due to the risk of arterial damage and subsequent need for emergency bypass surgery.

3. The capacity of an open heart surgery program is 500 open heart procedures per year for the initial open heart surgery unit and each additional dedicated open heart surgery unit (i.e., each operating room equipped and staffed to perform open heart surgery has a maximum capacity of 500 procedures annually).

4. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit within three years after initiation in any institution in which open heart surgery is performed for adults. In institutions performing pediatric open heart surgery there should be a minimum of 100 pediatric heart operations per open heart surgery unit; at least 75 should be open heart surgery.

5. New open heart surgery services shall be approved only if the following conditions are met:

   A. Each existing unit in the service area (defined as all facilities within 60 minutes one way automobile travel, excluding any facilities located in either North Carolina or Georgia) is performing an annual minimum of 350 open heart surgery procedures per open heart surgery unit for adult services (70 percent of functional capacity). The standard for pediatric open heart cases in pediatric services is 130 procedures per unit. An exception to this requirement may be authorized should an applicant meet both of the following criteria:

      1. There are no open heart surgery programs located in the same county as the applicant; and

      2. The proposed facility currently offers cardiac catheterization services and provided a minimum of 1,200 diagnostic equivalents in the previous year of operation.

   B. An applicant must project that the proposed service will perform a minimum of 200 adult open heart surgery procedures annually per open heart surgery unit within three years after initiation (the standard for pediatric open heart surgery shall be 100 procedures annually per open heart surgery unit within three years after initiation):

      1. The applicant shall provide epidemiological evidence of the incidence and prevalence of conditions for which open heart surgery is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

      2. The applicant shall provide an explanation of how the applicant projects the utilization of the service and the effect of its projected utilization on other open heart surgery services, including:

         a. The number of patients of the applicant hospital who were referred to other open heart surgery services in the preceding three years and the number of these patients who could have been served by the proposed service;

         b. The number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall

document the services, if any, from which these patients will be drawn; and

c. The existing and projected patient origin information and referral patterns for each open heart surgery service serving patients from the area proposed to be served shall be provided.

6. No new open heart surgery programs shall be approved if the new program will cause the annual caseload of other programs within the proposed service area to drop below 350 adult procedures or 130 pediatric procedures per open heart surgery unit.

7. Expansion of an existing open heart surgery service shall only be approved if the service has operated at a minimum use rate of 70 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year in the new open heart surgery unit. The applicant shall document the other service providers, if any, from which these additional patients will be drawn.

8. The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk and shall state whether high-risk cases are or will be performed or high-risk patients will be served.

9. Open heart surgery services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform open heart surgery and therapeutic cardiac catheterizations. In addition, standards should be established to assure that each physician using the service will be involved in adequate numbers of applicable types of open heart surgery and therapeutic cardiac catheterizations to maintain proficiency.

10. The open heart surgery service will have the capability for emergency coronary artery surgery, including:

A. Sufficient personnel and facilities available to conduct the coronary artery surgery on an immediate, emergency basis, 24 hours a day, 7 days a week;

B. Location of the cardiac catheterization laboratory(ies) in which therapeutic catheterizations will be performed near the open heart surgery operating rooms; and

C. A predetermined protocol adopted by the cardiac catheterization service governing the provision of PTCA and other therapeutic or high-risk cardiac catheterization procedures or the catheterization of patients at high risk and defining the plans for the patients' emergency care. These high-risk procedures should only be performed with

open heart surgery backup. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

11. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

Volume is a proxy measure for quality. Higher volumes have been associated with better outcomes although some low-volume hospitals have very good outcomes. There is a potential for variation in CABG rates between area populations.

The DHEC Hospital Acquired Infections (HAI) report includes a standardized Surgical Site Infection (SSI) ratio for Coronary Artery Bypass Grafts. All South Carolina open heart surgery providers should be lower than or not different than their statistically expected ratios. For 2009, Palmetto Health Richland and Providence Hospital had statistically significantly lower SSIs than projected; all other providers were within their expected ranges. Source:

http://www.scdhec.gov/health/disease/hai/docs/Table%201.%20Coronary%20Artery%20Bypass%20(Chest%20and%20Donor%20Incision).pdf

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and
j. Adverse Effects on Other Facilities.

The Department makes the following findings:

1. Open heart surgery services are available within sixty (60) minutes travel time for the majority of residents of South Carolina;

2. Based upon the standards cited above, most of the open heart surgery providers are currently utilizing less than the functional capability (i.e. 70% of maximum capacity) of their existing surgical suites;

3. The preponderance of the literature on the subject indicates that a minimum number of procedures is recommended per year in order to develop and maintain physician and staff competency in performing these procedures; and

4. Increasing geographic access may create lower volumes in existing programs causing a potential reduction in quality and efficiency, exacerbate existing problems regarding the availability of nursing staff and other personnel, and not necessarily reduce waiting time since other factors (such as the referring physician's preference) would still need to be addressed.

5. Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. Thus, the Department establishes minimum standards that must be met by a hospital in order to provide open heart surgery. Specifically, a hospital is required to project a minimum of 200 open heart surgeries annually within three years of initiation of services. This number is considered to be the minimum caseload required to operate a program that maintains the skill and efficiency of hospital staff and reflects an efficient use of an expensive resource. It is in the public's interest that facilities achieve their projected volumes.

6. The State Health Planning Committee recognizes the important correlation between volume and proficiency. The Committee further recognizes that the number of open heart surgery cases is decreasing and that maintaining volume in programs is very important to the provision of quality care to the community.

The benefits of improved accessibility will not outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

OPEN HEART SURGERIES

REGION/FACILITY	# OPEN HEART UNITS	FY07 ADULTS	FY07 PEDS	FY08 ADULTS	FY08 PEDS	FY09 ADULTS	FY09 PEDS
I							
ANMED HEALTH MEDICAL CENTER	2	225		226		216	
GREENVILLE MEMORIAL MEDICAL CENTER	4	646		583		596	
ST FRANCIS - DOWNTOWN	2	305		347		392	
SPARTANBURG REGIONAL MEDICAL CENTER	2	433		432		400	
TOTAL REGION I	10	1,609		1,588		1,604	
II							
SELF REGIONAL HEALTHCARE	2	139		116		106	
LEXINGTON MEDICAL CENTER *1*	1						
PALMETTO HEALTH RICHLAND	2	436		435		438	
PROVIDENCE HOSPITAL *1*	3	843		784		692	
PIEDMONT MEDICAL CENTER	2	149		164		155	
TOTAL REGION II	10	1,567		1,499		1,391	
III							
CAROLINAS HOSPITAL SYSTEM	2	202		201		177	
MCLEOD REGIONAL MEDICAL CENTER	3	350		429		327	
GRAND STRAND REGIONAL MEDICAL CENTER	2	439		392		361	
TOTAL REGION III	7	991		1,022		865	
IV							
AIKEN REGIONAL MEDICAL CENTER	1	101		65		62	
HILTON HEAD HOSPITAL	1	53		55		67	
MUSC MEDICAL CENTER	3	314	212	376	215	378	209
ROPER HOSPITAL	2	427		409		462	
TRIDENT REGIONAL MEDICAL CENTER	1	202		205		224	
VA HOSPITAL (CHARLESTON)	1	(110)					
TOTAL REGION IV	9	1,097	212	1,110	215	1,193	209
STATEWIDE TOTALS	35	5,264	212	5,219	215	5,053	209

1 LEXINGTON SERVICE ESTABLISHED THROUGH THE TRANSFER OF AN OPEN HEART SUITE FROM PROVIDENCE 6/18/10, SC-10-19.

CHAPTER IX

MEGAVOLTAGE RADIOTHERAPY & RADIOSURGERY

Cancer is a group of many related diseases, all involving out-of-control growth and spread of abnormal cells. These cells accumulate and form tumors that invade and destroy normal tissue. Cancer is the second leading cause of death, both nationally and in South Carolina, accounting for approximately 22% of all deaths. According to the South Carolina Central Cancer Registry (SCCCR), there were 21,532 new cases of cancer diagnosed in South Carolina in 2006 and 9,063 cancer deaths. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment. The overall five-year survival rate is approximately 62%.

Megavoltage radiation has been utilized for decades as a standard modality for cancer treatment. It is best known as Radiation Therapy, but is also called Radiotherapy, X-Ray Therapy, or Irradiation. It kills cancer cells and shrink tumors by damaging their genetic material, making it impossible for these cells to continue to grow and divide. Approximately 50% of all cancer patients receive radiation therapy at some time during their illness, either alone or in combination with surgery or chemotherapy. It can be used as a therapeutic treatment (to attempt to cure the disease), a prophylactic treatment (to prevent cancer cells from growing in the area receiving the radiation) or as a palliative treatment (to reduce suffering and improve quality of life when a cure is not possible).

Beams of ionizing radiation are aimed to meet at a specific point and delivery radiation to that precise location. The amount of radiation used is measured in "gray" (Gy) and varies depending on the type and stage of cancer being treated. Radiation damages both cancer cells and normal cells, so the goal is to damage as many cancer cells as possible, while limiting harm to nearby healthy tissue. A typical course of treatment lasts for two to 10 weeks, depending on the type of cancer and the treatment goal. The relevant CPT Procedure codes are: 77371-77373, 77401-77404, 77406-77409, 77411-77414, 77416, 77418, 77432 and 77470.

1. Definitions:

There are varying types of radiation treatment and definitions are often used interchangeably. The following definitions apply:

Adaptive Radiation Therapy (ART): Patient setup and/or radiation delivery is evaluated and modified periodically during the treatment course based on imaging and dose measurements made prior to or during treatment.

Conformal Radiation Therapy (CRT): Since the target often has a complex shape, CT, MRI, or PET is used to create a 3-D image of the tumor. Using the image, the computer designs the radiation beams to be shaped exactly (conform) to the contour of the treatment area. Synonyms include Conformal External Beam Radiation Therapy (CEBRT), 3-D radiation therapy (3-DRT), 3-D Conformal Beam Radiation Therapy (3-

DCBRT), 3-D Conformal Radiation Therapy (3-DCRT), and 3-D External Beam Radiation Therapy (3-DEBRT, 3-DXBRT).

Conventional External Beam Radiotherapy (2DXRT) is delivered via 2-D beams using a linear accelerator. Conventional refers to the way the treatment is planned on a simulator to target the tumor. It consists of a single beam of radiation delivered to the patient from several directions. It is reliable, but is being surpassed by Conformal and other more advanced modalities due to the reduced irradiation of healthy tissue.

Because of the increased complexity of treatment planning and delivery techniques, Electronic Portal Imaging Devices (EPIDs) have been developed. The most common EPIDs are video-based systems; on-line digital port images are captured and analyzed before or during treatment. These systems are used for pre-treatment verification of IMRT fields and to reduce errors in patient positioning.

Fractionation: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. Hyperfractionation (Superfractionation) refers to radiation given in smaller doses twice a day. In Hypofractionation, individual doses are given less often than daily, such as in two-five sessions.

Image-Guided Radiation Therapy (IGRT) combines with IMRT or 3DCRT to visualize (by means of EPIDs, kV scans or mV scans) the patient's anatomy during treatments. This allows for confirmation of beam location and adjustment of the beams if needed during treatments due to breathing. IGRT facilitates more accurate patient positioning and reduces healthy tissue damage.

IMRT (Intensity Modulated Radiation Therapy) creates a 3-D radiation dose map to treat the tumor. It uses a multi-leaf collimator to modulate or control the outlines and intensity of the radiation field during cancer treatment. Due to its precision it can spare more healthy tissue, but it also requires detailed data collection and takes longer than conventional therapy.

Stereotactic body radiation therapy (SBRT) is a precision radiation therapy delivery concept derived from cranial stereotactic radiosurgery. It is characterized by one to five fraction delivery of focal high-dose radiation while limiting dose to surrounding normal tissues. SBRT has become an established treatment technique for lung, liver, and spinal lesions.

Stereotactic Radiosurgery (SRS) is a single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. The patient's head is placed in a special frame, which is attached to the patient' skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient's head. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation

with radiosurgery versus smaller fractions over time with radiation therapy. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.

Stereotactic Radiation Therapy (SRT) is an approach similar to Stereotactic Radiosurgery which delivers radiation to the target tissue. However, the total dose of radiation is divided into several smaller doses given over several days, rather than a single large dose. The treatment time per session typically ranges from 30 to 90 minutes for two-five sessions. It can be used to treat both brain and extracranial tumors.

2. Types of Radiation Equipment:

A. Particle Beam (Proton):

Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Unlike the other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin. There are only a few facilities that operate particle beam (or cyclotron) units, which can be used to treat brain cancers and fractionated to treat other cancers. There are currently only 5 facilities in the United States and the cost of more than $100 million will limit their expansion.

B. Linear Accelerator (X-Ray):

The linear accelerator produces high energy x-rays that are collected to form a beam that matches the size and shape of the patient's tumor. The patient lies on a movable couch and radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry, moving the couch, or moving the accelerator with a robotic arm. The accelerator must be located in a room with lead and concrete walls to keep the rays from escaping. A conventional linac requires modifications, such as additional equipment, in order to be used for IMRT or other advanced techniques.

Minimal equipment requirements for a linear accelerator include:

1. at least 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm;

2. access to an electron beam source or a low energy X-ray unit;

3. adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department;

4. capability to provide appropriate dose distribution information for external beam treatment and brachytherapy;

5. equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units);

6. field-shaping capability; and

7. access to CT scanning capability.

The capacity standards for a linear accelerator vary by the capability of the equipment. A conventional linear accelerator, either with or without EPID, has a capacity of 7,000 treatments per year, based upon an average of 28 patients treated per day, 5 days per week, 50 weeks per year. Linacs with IMRT and IGRT systems (such as Tomotherapy and Novalis TX) take longer to set up and perform treatments than those relying on previously generated images. Therefore, a lower capacity of 5,000 treatments per year is established for such equipment (20 patients treated per day, 5 days per week, 50 weeks per year). IMRT/IGRT machines that perform stereotactic procedures have a lower capacity of 4,500 treatments per year (18 patients treated per day, 5 days per week, 50 weeks per year). MUSC has three linacs designated with a capacity of 5,000 treatments and two with a capacity of 4,500. The Tomotherapy unit at Spartanburg Regional has been designated with a capacity of 4,500 treatments and the Tomotherapy unit at Carolina Regional Radiation Center has been designated as having a capacity of 5,000 treatments per year. The capacities for these machines and the need calculations for their service areas have been adjusted accordingly.

There is also linac equipment designed strictly to provide Stereotactic Radiotherapy in 1-5 treatment sessions. These specialized linacs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 2,000 treatments per year per unit, based on 8 treatments per day, 5 days per week, for 50 days per year. The Cyberknife at Roper Hospital is the only equipment so designated. It is an older generation unit with a previously designated capacity of 1,000 treatments per year. The capacity and need calculations for this facility and service area have also been adjusted.

C. Cobalt-60 (Photon):

This modality, best known by the trade name of Gamma Knife, is used to perform Stereotactic Radiosurgery. It is primarily used to treat brain tumors, although it can also be used for other neurological conditions like Parkinson's Disease and Epilepsy. Its use is generally reserved for cancers that are difficult or dangerous to treat with surgery. The radiation damages the genetic code of the tumor in a single treatment, preventing it from replicating and causing it to slowly shrink. Installation of a Gamma Knife system costs between $3.4 and $5 million, plus an additional $0.25 to $0.5 million every 5-10 years to replenish the cobalt-60 power source.

The Gamma Knife consists of a large shield surrounding a large helmet-shaped device with 201 separate, fixed ports that allow the radiation to enter the patient's head in small beams that converge on the designated target. A rigid frame is attached to the patient's

skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging, to accurately determine the position of the target. The computer system develops a treatment plan to position the patient and the paths and doses of radiation. The patient is positioned with the head affixed to the couch, and the treatment is delivered. The patient goes home the same day.

3. Status of South Carolina Providers:

A. Linear Accelerators:

There are currently 28 facilities either operating or approved for a total of 56 linear accelerators in South Carolina. In 2009, the 47 operational linear accelerators performed 264,116 treatments, or an average of 5,620 treatments per unit.

B. Gamma Knife:

Palmetto Health Richland performed 210 Gamma Knife treatments in 2009. MUSC's Gamma Knife became operational in February 2010.

4. Certificate of Need Standards for Radiotherapy

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.

2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

3. IMRT/IGRT linear accelerators performing stereotactic procedures have a capacity of 4,500 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

4. Linear Accelerators designed strictly to provide Stereotactic Radiotherapy have a capacity of 2,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

5. There are 13 service areas established for Radiotherapy units as shown on the following chart.

6. New Radiotherapy services shall only be approved if the following conditions are met:

A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and

B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.

7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.

8. The applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes.

9. The applicant must affirm the following:

A. All treatments provided will be under the control of a board certified or board eligible radiation oncologist;

B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

C. The applicant will have access to simulation equipment capable of precisely producing the geometric relationships of the equipment to be used for treatment of the patient;

D. The applicant will have access to a custom block design and cutting system; and

The institution shall operate its own tumor registry or actively participate in a central tumor registry.

Quality

Incorrect doses of radiation can be dangerous. Two patients in New York died from lethal overdoses. In response, the Medical Imaging & Technology Alliance and the Advanced Medical Technology Alliance recently announced the Radiation Therapy Readiness Check Initiative, which is intended to incorporate safety-check mechanisms into radiation therapy equipment. The manufacturers have agreed to make equipment modifications to improve patient safety, by preventing equipment from operating unless the users verify that safeguards are in place.

The initiative requires medical physicists to record the performance of quality-assurance reviews of treatment plans. Technicians are required to perform beam modification checks, verify correct placement of machine accessories, and confirm correct patient placement. Individual manufacturers will be responsible for incorporating the safety-check software into new equipment and creating software add-ons that can be incorporated into existing equipment. However, some older machines may not be capable of adding the safeguards.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

RADIOTHERAPY

SERVICE AREAS	2009 POPULATION	# OF LIN ACC	POP PER LIN ACC	TOTAL AREA TREATMENTS	TREATMENTS PER LIN ACC	PLANNING AREA CAPACITY	PERCENT CAPACITY
ANDERSON,OCONEE	253,230	3	84,410	18,728	6,243	21,000	89.2%
GREENVILLE,PICKENS	541,950	6	90,325	29,754	4,959	42,000	70.8%
CHEROKEE,SPARTANBURG UNION	364,780	5	72,956	18,512	3,702	32,500	57.0%
CHESTER,LANCASTER,YORK	288,250	3	96,083	13,416	4,472	21,000	63.9%
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	232,640	2	116,320	6,747	3,374	14,000	48.2%
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	712,910	9	79,212	47,211	5,246	63,000	74.9%
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	340,910	5	68,182	22,191	4,438	35,000	63.4%
CLARENDON,LEE,SUMTER	170,600	2	85,300	10,812	5,406	14,000	77.2%
GEORGETOWN,HORRY WILLIAMSBURG	332,400	4	83,100	20,918	5,230	26,000	80.5%
BAMBERG,CALHOUN ORANGEBURG	128,340	2	64,170	6,545	3,273	14,000	46.8%
ALLENDALE,BEAUFORT, HAMPTON,JASPER	200,890	2	100,445	17,108	8,554	14,000	122.2%
BERKELEY,CHARLESTON COLLETON,DORCHESTER	647,160	11	58,833	44,288	4,026	60,000	73.8%
AIKEN,BARNWELL	187,170	2	93,585	7,886	3,943	14,000	56.3%
STATE TOTAL	4,401,230	56	78,593	264,116	4,716	370,500	71.3%

MEGAVOLTAGE VISITS

REGION & FACILITY	COUNTY	# UNITS	FY 2007	FY 2008	FY 2009
REGION I					
ANMED HEALTH MEDICAL CENTER	ANDERSON	2	10,811	12,781	12,449
GIBBS REGIONAL CANCER CTR SATELLITE *1*	CHEROKEE	(1)	---	---	---
CANCER CENTERS OF THE CAROLINAS	GREENVILLE	1	6,175	5,821	4,834
CANCER CENTERS CAROLINAS - EASTSIDE		1	11,563	10,553	9,487
GREENVILLE MEMORIAL MEDICAL CENTER		3	17,669	18,309	15,433
GREER MEDICAL CAMPUS CANCER CTR *2*		1	---	---	---
CANCER CENTERS CAROLINAS - OCONEE CO.	OCONEE	1	6,303	6,550	6,279
CANCER CENTER CAROLINAS - MARY BLACK *3*	SPARTANBURG	1	---	---	---
SPARTANBURG REGIONAL MED CTR		3	18,853	17,480	18,512
VILLAGE AT PELHAM CANCER CENTER *1*		1	---	---	---
REGION II					
SELF REGIONAL HEALTHCARE	GREENWOOD	2	6,060	6,589	6,747
LANCASTER RADIATION THERAPY CTR *4*	LANCASTER	1	---	---	---
LEXINGTON MEDICAL CENTER	LEXINGTON	2	12,215	9,599	10,433
NEWBERRY ONCOLOGY ASSOCIATES *5*	NEWBERRY	1	---	---	---
PALMETTO HEALTH RICHLAND	RICHLAND				
LINEAR ACCELERATORS		2	12,065	11,710	14,107
GAMMA KNIFE		1	232	206	210
SOUTH CAROLINA ONCOLOGY ASSOCIATES		4	20,242	26,881	22,671
ROCK HILL RADIATION THERAPY CENTER	YORK	2	14,721	14,210	13,416
REGION III					
CAROLINAS HOSPITAL SYSTEM	FLORENCE	1	5,358	4,557	5,015
MCLEOD REGIONAL MEDICAL CENTER		4	17,842	19,164	17,176
GEORGETOWN MEMORIAL HOSPITAL	GEORGETOWN	1	5,466	5,903	5,305

CAROLINA REGIONAL RADIATION CENTER		HORRY	3	13,107	14,335	15,613
TUOMEY		SUMTER	2	9,892	9,407	10,812
REGION IV						
RADIATION ONCOLOGY CTR OF AIKEN	*6*	AIKEN	2	6,916	7,371	7,886
BEAUFORT/HILTON HEAD RAD ONCOLOGY CTR		BEAUFORT	1	5,745	6,369	6,182
BEAUFORT MEMORIAL HOSPITAL	*7*		1	5,143	5,143	10,926
MUSC MEDICAL CENTER	*8*	CHARLESTON				
LINEAR ACCELERATORS			5	16,810	16,806	18,184
GAMMA KNIFE			1			
ROPER HOSPITAL	*9*		4	12,877	13,403	14,440
TRIDENT MEDICAL CENTER	*10*		2	11,971	11,461	11,664
REG MED CTR ORANGEBURG/CALHOUN	*11*	ORANGEBURG	2	5,545	7,060	6,545
TOTAL			**56**	**253,349**	**261,462**	**264,116**

1 GIBBES LINAC APPROVED 3/31/03; APPEALED. CON TO MOVE PROPOSED GIBBES LINAC TO VILLAGE AT PELHAM APPEALED 2/12/08. CONS ISSUED FOR GIBBES BY SUPREME CT RULING.
2 CON ISSUED 10/12/07, SC-07-53.
3 CON ISSUED BY SUPREME COURT RULING 3/31/10.
4 CON APPROVED 2/15/08; APPEALED. APPEAL DISMISSED 8/5/09; SC-09-39 ISSUED 8/12/09.
5 CON APPROVED 3/20/06.
6 CON ISSUED TO TRANSFER OWNERSHIP FROM AIKEN REGIONAL & ADD 2ND LINAC 6/11/09, SC-09-29.
7 DATA NOT AVAILABLE FOR 2008
8 CON FOR GAMMA KNIFE ISSUED 6/8/09. CON FOR 5TH LINAC ISSUED 7/8/09.
9 CON ISSUED FOR A CYBERKNIFE LINEAR ACCELERATOR 8/10/06. CON APPROVED FOR 3RD CONVENTIONAL LINAC 8/5/09.
10 CON ISSUED FOR REPLACEMENT LINAC 2/26/09 SC-09-07.
11 CON ISSUED FOR 2ND LINAC 10/14/10, SC-10-31.

Certificate of Need Standards for Stereotactic Radiosurgery

1. The capacity of a dedicated Stereotactic Radiosurgery unit is 300 procedures annually. This is based on an average of two procedures per day times three days per week times 50 weeks per year.

2. The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes one-way automobile travel time.

3. New Radiosurgery services shall only be approved if the following conditions are met:

A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the most recent year; and

B. An applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of service, without reducing the utilization of existing units below the 80 percent threshold.

4. Expansion of an existing radiosurgery service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.

5. The applicant shall project the utilization of the service, to include:

A. Epidemiological evidence of the incidence and prevalence of conditions for which radiosurgery treatment is appropriate, to include the number of potential patients for these procedures;

B. The number of patients of the applicant who were referred to other radiosurgery providers in the preceding three years and the number of those patients who could have been served by the proposed service; and

C. Current and projected patient origin information and referral patterns for the facility's existing radiation therapy services. The applicant shall document the number of additional patients, if any, that will be generated through changes in referral patterns, recruitment of specific physicians or other changes in circumstances.

6. The applicant must include letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

7. The applicant must document that protocols will be established to assure that all clinical radiosurgery procedures performed are medically necessary and that alternative treatment modalities have been considered.

8. The applicant must affirm the following:

A. The radiosurgery unit will have a board certified neurosurgeon and a board certified radiation oncologist, both of whom are trained in stereotactic radiosurgery;

B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

C. Dosimetry and calibration equipment and a computer with the appropriate software for performing radiosurgical procedures will be available;

D. The applicant has access to a full range of diagnostic technology, including CT, MRI and angiography; and

E. The institution shall operate its own tumor registry or actively participate in a central tumor registry.

9. Due to the unique nature and limited need for this type of equipment, the applicant should document how it intends to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER X

POSITRON EMISSION TOMOGRAPHY (PET) AND PET/CT

Positron Emission Tomography (PET) uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. It allows the study of metabolic processes such as oxygen consumption and utilization of glucose and fatty acids. Cancer cells utilize more glucose than normal cells, so PET can be used to reveal the presence or track the spread of cancer. It is quantitative and very sensitive, so only small amounts of isotopes are needed. The isotopes only have about a two hour half-life and are quickly expelled from the body.

PET was developed in the 1970s and was primarily used for research focusing on cerebral function and detection and assessment of coronary artery disease. Recent research has centered on the diagnosis and staging of cancer and neurological applications such as epilepsy, Alzheimer's and Parkinson's diseases. PET is covered for Medicare patients with lung, breast, colorectal, head and neck and esophageal cancers; melanomas; certain thyroid diseases; neurology; and heart disease uses.

The process takes approximately 45 minutes to an hour to perform. A Computerized Tomography (CT) scanner produces cross-sectional images of anatomical details of the body. These images are taken separately, and then fused with the PET images for interpretation. The process requires a nuclear medical technologist certified for both PET and CT or dually certified in radiography.

Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time. A PET/CT scanner costs between $2,000,000-$2,7000,000 dollars. Installing and operating a PET scanner typically costs around $1,600,000 in capital costs plus annual staffing and operational costs of $800,000. Charges vary from around $2,500 - $4,000 depending on the type and location of the scan.

Due to the on-going development of this technology, it is anticipated that PET and PET/CT will become a standard diagnostic modality in the fields of cardiology, oncology and neurology. Due to the current cost of this technology and the uses approved for reimbursement, it is more appropriate that this technology be available for health care facilities providing specialized therapeutic services such as open heart surgery and radiation oncology. Note: in the Certificate of Need standards cited below, the terms PET and PET/CT are interchanged. The Department does not differentiate between these modalities in defining these standards. The addition of a CT component to an existing PET service is not considered to be a new service that would trigger CON review and is interpreted by the Department to be the replacement of like equipment with similar capabilities.

The operational or approved PET scanners in the state are listed on the following pages.

POSITRON EMISSION TOMOGRAPHY (PET) AND PET-CT UTILIZATION

REGION/COUNTY	FACILITY	SCANNERS	FY07 SCANS	FY08 SCANS	FY09 SCANS	CON/DATE
I						
ANDERSON	ANMED HEALTH CANCER CENTER	MOBILE 2 DAYS	423	509	502	
GREENVILLE	THE CAROLINAS CLINICAL PET INSTITUTE	FIXED	1,958	2,330	2,413	
GREENVILLE	GREENVILLE MEMORIAL HOSPITAL	MOBILE 4 DAYS	713	661	908	
SPARTANBURG	SPARTANBURG REGIONAL MEDICAL CTR	FIXED	1,234	1,589	1,749	
II						
GREENWOOD	SELF REGIONAL HEALTHCARE	MOBILE 3 DAYS	415	545	746	
LEXINGTON	LEXINGTON MED CTR - LEXINGTON	MOBILE 3 DAYS	340	444	428	
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	904	954	946	
RICHLAND	SOUTH CAROLINA HEART CENTER	FIXED	—	—	549	CON 3/17/08
RICHLAND	SOUTH CAROLINA ONCOLOGY ASSOC	FIXED	1,709	2,213	2,256	
YORK	PIEDMONT MEDICAL CENTER	MOBILE 2 DAYS	884	1,085	1,117	
III						
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE 1 DAY	234	248	230	
FLORENCE	MCLEOD REGIONAL MEDICAL CENTER	FIXED	596	672	667	
GEORGETOWN	GEORGETOWN MEMORIAL HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	227	237	211	CON 10/10/08 TO SHARE 1 DAY / 2 WEEKS
GEORGETOWN	WACCAMAW COMMUNITY HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	—	7	164	CON 10/10/08 TO SHARE 1 DAY / 2 WEEKS
HORRY	COASTAL CANCER CENTER	FIXED	—	650	1,306	
HORRY	GRAND STRAND REGIONAL MEDICAL CTR	MOBILE 2 DAYS	951	776	636	
HORRY	CONWAY HOSPITAL	MOBILE 2 DAYS	123	199	128	
SUMTER	TUOMEY	MOBILE 1/2 DAY	160	191	227	
IV						
AIKEN	AIKEN REGIONAL MEDICAL CENTER	MOBILE 1 DAY	426	341	347	
BEAUFORT	BEAUFORT IMAGING CENTER	MOBILE 2 DAYS	224	226	266	
CHARLESTON	MUSC MEDICAL CENTER	FIXED	1,186	1,559	1,966	
CHARLESTON	ROPER HOSPITAL	FIXED	1,017	1,390	1,423	
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE 1 DAY	431	467	408	
CHARLESTON	TRIDENT HOSPITAL	FIXED	—	—	—	CON 2/26/09
JASPER	SOUTH CAROLINA CANCER SPECIALISTS	FIXED	—	—	293	EXEMPTION 7/24/07
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE 2 DAYS	50	66	75	CONVERTED TO PET/CT 6/17/09
		TOTALS	14,205	17,359	19,961	

Certificate of Need Standards

(1) Hospitals that provide specialized therapeutic services (open heart surgery and/or radiation therapy) should have either fixed or mobile PET services for the diagnosis of both inpatients and outpatients. Other hospitals must document that they provide a sufficient range of comprehensive medical services that would justify the need for PET services. Applicants for a freestanding PET service not operated by a hospital must document referral agreements from health care providers that would justify the establishment of such services.

(2) Full-time PET scanner service is defined as having PET scanner services available five days per week. Fixed PET scanners are considered to be in operation five days per week. Capacity is considered to be 1,500 procedures annually. For PET/CT equipment, only procedures that utilize the PET component should be counted; procedures using the CT component as a stand-alone scanner are not included. Capacity for shared mobile services will be calculated based on the number of days of operation per week at each participating facility.

(3) Applicants proposing new fixed PET services must project at a minimum 750 PET clinical procedures per year (three clinical procedures/day x 250 working days) by the end of the third full year of service. The projection of need must include proposed utilization by both patient category and number of patients to be examined, and must consider demographic patterns, patient origin, market share information, and physician/patient referrals. An existing PET service provider must be performing at 1,250 clinical procedures (five clinical procedures x 250 days) per PET unit annually prior to the approval of an additional PET machine.

(4) In order to promote cost-effectiveness, the use of shared mobile PET units should be considered. Applicants for a shared mobile scanner must project an annual minimum of three clinical procedures/day times the number of days/week the scanner is operational at the facility by the end of the third full year of service.

(5) The applicant must demonstrate through cooperative and sharing agreements and letters of support how it will accommodate physicians, other health care institutions and patients from its own region and beyond.

(6) The applicant agrees in writing to provide to the Department utilization data on the operation of the PET service.

(7) The Department encourages all applicants and providers to share their outcome data with appropriate registries and research studies designed to improve the quality of patient care.

(8) A provider seeking Medicare reimbursement must be accredited after January 1, 2012.

Quality

CMS recently announced that PET/CT providers will have to be accredited by January 1, 2012 in order to ensure the quality of the pictures produced and the safety of the Medicare beneficiaries undergoing these procedures. TJC, the American College of Radiology and the Intersocietal Accreditation Commission have been designated as accrediting organizations by CMS.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER XI

OUTPATIENT FACILITIES

Outpatient facility means a facility providing community service for the diagnosis and treatment of ambulatory patients: (1) that is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of a licensed physician; or (3) that offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope, but generally include diagnostic laboratory, radiology, and clinical referral services.

A. Ambulatory Surgical Facility

Ambulatory surgery, often described as outpatient or same-day surgery, may be provided in either a hospital or a freestanding Ambulatory Surgical Facility (ASF). An ASF is a distinct, freestanding, self-contained entity that is organized, administered, equipped and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, for which patients are scheduled to arrive, receive surgery, or related care, treatment, procedures, and/or services, and be discharged on the same day. The owner or operator makes the facility available to other providers who comprise an organized professional staff, i.e. an open medical staff. This definition does not apply to any facility used as an office or clinic for the private practice of licensed health care professionals.

For purposes of this Plan, an endoscope is defined as a flexible, semi-flexible or rigid instrument, which may or may not have a light attached, that is inserted into a natural orifice in a non-sterile, clean environment, to visually inspect for purposes of screening and diagnosis and to perform therapeutic treatment of the interior of a bodily canal or a hollow organ (such as the colon, bladder, stomach or nasal sinuses).

An Endoscopy ASF is defined as one organized, equipped, and operated exclusively for the purpose of performing surgical procedures or related treatments through the use of an endoscope. Any appropriately licensed and credentialed medical specialist can perform endoscopy only surgical procedures or related treatments at an Endoscopy ASF.

A substantial increase has occurred in both the number and percentage of ambulatory surgeries performed and in the number of approved ASFs. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost. However, hospitals have expressed concern that ASFs that are not hospital joint ventures are impacting their ability to fund their services. CMS has revised the payment system for ASFs, setting a new compensation rate of 65% of the hospital outpatient rate under Medicare, to be phased in by 2011. This new rate is anticipated to particularly impact endoscopy centers, which are currently paid 89% of the hospital rate, while other specialties may receive increased reimbursement. At the same time, CMS added more than 700 procedures to the list for which ASFs can be reimbursed.

In 2008, a total of 344,612 outpatient surgeries and 258,974 endoscopies were performed in either a freestanding surgical center or a hospital in South Carolina, accounting for 69.0% of all surgeries and 85.1% of all endoscopies.

Certificate of Need Standards

1. The county in which the proposed facility is to be located is considered to be the service area for inventory purposes. The applicant may define a proposed service area that encompasses additional counties, but the largest percentage of the patients to be served must originate from the county in which the facility is to be constructed.

2. The applicant must identify the physicians who are affiliated or have an ownership interest in the proposed facility by medical specialty. These physicians must identify where they currently perform their surgeries and whether they anticipate making any changes in staff privileges or coverage should the application be approved.

3. For a new facility, the applicant must document where the potential patients for the facility will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

4. The applicant must document the need for the expansion of or the addition of an ASF, based on the most current utilization data available. This need documentation must include the projected number of surgeries or endoscopic procedures to be performed by medical specialty. The existing resources must be considered and documentation presented as to why the existing resources are not adequate to meet the needs of the community.

5. It is recommended that an application for a new ASF should contain letters of support from physicians in the proposed service area other than those affiliated with the proposed facility.

6. The applicant must document the potential impact that the proposed new ASF or expansion of an existing ASF will have upon the existing service providers and referral patterns.

7. All new Certificate of Need approvals by the Department will not restrict the specialties of ASFs. However, the Department believes that Ambulatory Surgery Facilities open to and equipped for all surgical specialties will better serve the community than those targeted towards a single specialty or group of

practitioners. For an ASF approved to perform only endoscopic procedures, another CON would be required before the center could provide other surgical specialties.

8. All proposed Ambulatory Surgical Facilities, other than those restricted to endoscopic procedures only, must have a minimum of two operating rooms.

9. Before an application for a new general Ambulatory Surgery Facility can be accepted for filing in a county having a current population of less than 100,000 people, all general ASFs in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for a ASF filing in a county having a current population of greater than 100,000 people.

10. Endoscopy suites are considered separately from other operating rooms. Therefore, endoscopy-only ASF's do not impact other ASF's and are not considered competing applicants for CON review purposes. Before an application for a new endoscopy-only ASF can be accepted for filing in a county having a current population of less than 100,000 people, all ASFs with endoscopy suites in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs with endoscopy suites must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for a new endoscopy-only ASF filing in a county having a current population of greater than 100,000 people.

11. The approval of a new general or endoscopy-only ASF in a county does not preclude an existing facility from applying to expand its number of operating rooms and/or endoscopy suites.

12. The applicant for a new ambulatory surgery facility must provide a written commitment that the facility will accept Medicare and Medicaid patients, and that un-reimbursed services for indigent and charity patients will be provided at a percentage that is comparable to all other existing ambulatory surgery facilities, if any, in the service area.

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Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements and must commit to seek accreditation from CMS or any accrediting body with deemed status. Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most South Carolina residents. Most ASFs operate five days a week, with elective surgery being scheduled several days in advance.

Quality

The ASC Quality Collaboration (ASCQC) is a voluntary cooperative effort between a number of organizations and companies working to ensure that quality data are measured and reported in a meaningful way. Participants in the National Quality Forum (NQF) include CMS, TJC, AAAJC, American College of Surgeons (ACOS), American Osteopathic Association (AOA), Association of periOPerative Registered Nurses (AORN), and Hospital Corporation of American (HCA).

The NQF has identified 6 standardized measurements that are feasible and useable as quality indicators. These are:

1. Patient burn;
2. Prophylactic IV antibiotic timing;
3. Patient falls within facility;
4. Wrong site, side, patient, procedure, or implant;
5. Hospital transfer/admission; and
6. Appropriate surgical site hair removal.

These quality indicators are proposed as goals for performance improvement measurement and improvement. CMS is developing a quality measure reporting system for ASFs, but the guidelines have not been released yet. Facilities will eventually face a two percent financial penalty for failing to report data, but, for now, any data collection efforts are voluntary.

If and when a data reporting system is created under CMS, the results for ASFs should be used in evaluating CON applications.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Adverse Effects on Other Facilities
c. Community Need Documentation;
d. Distribution (Accessibility);
e. Financial Feasibility;
f. Cost Containment;
g. Projected Revenues;
h. Projected Expenses;
i. Ability of the Applicant to Complete the Project; and
j. Staff Resources.

The number of surgeries performed on an outpatient basis and the number of ASFs approved and licensed have increased over time. However, there is concern that ASFs are being proposed as a method of increasing reimbursement for procedures currently being performed in physicians' offices through the "facility fee" built into the reimbursement mechanisms, to the detriment of a hospital's ability to provide the range of services needed. The benefits of improved accessibility will be weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

2009 ASF Utilization

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,993	643	5,636	1,664		
Bearwood Ambulatory Surgery Center	Anderson	1		1	1068		1,068	1,068		
Physician Surgery Center at AnMed Health	Anderson	3		3	2119		2,119	1,060		
Upstate Endoscopy Center	Anderson		2	2		5,756	5,756			
Center for Special Surgery, The	Greenville	2		2	1,886		1,886	943		
Cross Creek Surgery Center	Greenville	4		4	2,055		2,055	514		
Endoscopy Center of the Upstate	Greenville		3	3		5,000	5,000		1,667	
Greenville Endoscopy Center	Greenville		3	3		6,010	6,010		2,003	
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,001	6,001		2,000	
GHS Outpatent Surgery Center – Patewood	Greenville	6	2	8	5,869	2,363	8,232	978	1,182	*1*
Greenville Surgery Center	Greenville	4		4	2,896		2,896	724		
Jervey Eye Center	Greenville	3		3	3,493		3,493	1,164		
Upstate Surgery Center	Greenville	2		2	3,169		3,169	1,585		
Blue Ridge Surgery Center	Oconee	2		2	2,161		2,161	1,081		
Upstate Pain Management & Surgery Center	Oconee	2		2	687		687	344		
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	9	3	12	7,670	3,425	11,095	852	1,142	*2*
Spartanburg Surgery Center	Spartanburg	2		2	3,937		3,937	1,969		*3*
Surgery Center at Pelham	Spartanburg	4	2	6	3,359	1,611	4,970	840	806	
Westside Eye Center	Spartanburg	2		2						
Region II:										
Greenwood Endoscopy Center	Greenwood		4	4		8,314			2,079	

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Surgery Ctr. at Self Memorial Hospital	Greenwood	5		5	4,564	19	4,583	913		
Surgery Center at Edgewater	Lancaster	3	2	5	2,161	4	2,165	720	2	*4*
Surgery & Laser Center at Professional Park	Laurens	2		2	2,908		2,908	1,454		
Columbia Surgery Center	Lexington	2		2						
Midlands Endoscopy Center	Lexington		2	2		1,902			951	
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	2		2	3,267		3,267			
Outpt Surgery Center Lexington Med Ctr - Irmo	Lexington	4		4	1,646		1,646	412		
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	2,197	1,559	3,756	549	1,559	
South Carolina Endoscopy Center	Lexington		4	4		10,746	10,746		2,687	
Urology Surgery Center	Lexington	2		2	1,911		1,911	956		
Berkeley Endoscopy Center	Richland		2	2		2,422	2,422		1,211	
Columbia Eye Surgery Center	Richland	4		4	4,787		4,787	1,197		
Columbia GI Endoscopy Center	Richland		4	4		6,228	6,228		1,557	
Lake Murray Endoscopy Center	Richland		2	2		1,700	1,700		850	
Midlands Orthopaedics Surgery Center	Richland	3		3	5,393		5,393	1,798		
Palmetto Surgery Center	Richland	4		4	5,417		5,417	1,354		
Parkridge Surgery Center	Richland	4		4	2,576		2,576	644		
(Providence Hospital Surgery Center)	Richland	(4)		(4)						
South Carolina Endoscopy Center - North East	Richland		5	5		4,218	4,218		844	
South Carolina Med Endoscopy Ctr.	Richland		2	2		3,170	3,170		1,585	*5*
Carolina Surgical Center	York	4		4	5,874		5,874	1,469		
Center for Orthopaedic Surgery	York	3		3	3,732		3,732			
York County Endoscopy Center	York		3	3	1,500					*6*

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region III:										
Darlington Endoscopy Center	Darlington		2	2		678	678		339	
Florence Surgery & Laser Center	Florence	2		2	2,992		2,992	1,496		
McLeod Ambulatory Surgery Center	Florence	2		2	1,483		1,483	742		
Physicians Surgical Center of Florence	Florence	4	2	6	3,024	2,785	5,809	756	1,393	
Atlantic Surgery Center	Georgetown	1		1	1,200		1,200	1,200		
Bay Microsurgical Unit	Georgetown	1		1	3,519		3,519	3,519		
Waccamaw Endoscopy Center	Georgetown		1			1,986	1,986		1,986	
Carolina Bone and Joint Surgery Ctr.	Horry	3		3	3,139		3,139	1,046		7
Grande Dunes Surgery Center	Horry	3	2	5	2,318	637	2,955	773	319	
Ocean Ambulatory Surgery Center	Horry	2		2	1,784		1,784			
Parkway Surgery Center	Horry	2		2	2,415		2,415	1,208		
Rivertown Surgery Center	Horry	2		3	2,870	1,848	4,718	1,435		
Seacoast Med Ctr Ambulatory Surgery	Horry	3		3	1,999	1,174	3,173	666		
Strand GI Endoscopy Center	Horry		2	2		5,033	5,033		2,517	
Wesmark Ambulatory Surgery Facility	Sumter	2		2	1,564		1,564	782		
Region IV:										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	2,424	1,300	3,724	606	1,300	
Carolina Ambulatory Surgery Center	Aiken	1		1	2,986		2,986			
Bluffton-Okatie Outpatient Center	Beaufort	2	1	3	1,037	622	1,659	519	622	
Laser and Skin Surgery Center	Beaufort	2		2	2,623		2,623	1,312		
Outpatient Surgery Ctr. Hilton Head	Beaufort	3	2	5	3,626	2,268	5,894	1,813	1,134	8
Surgery Center of Beaufort	Beaufort	3		3	3,734	1,368	5,102	1,245		

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Roper Hospital Ambulatory Surgery - Berkeley	Berkeley	3		3	232	658	890	77		
Charleston Endoscopy Center	Charleston		4	4		9,316	9,316		2,329	
Charleston Surgery Center	Charleston	4	1	5	4,477	536	5,013	1,119	536	
Elms Endoscopy Center	Charleston		3	3		7,173	7,173		2,391	
Palmetto Endoscopy Center	Charleston		2	2		8,519	8,519		4,260	
Physicians' Eye Surgery Center	Charleston	2		2	2,685		2,685	1,343		
Roper Hosp Ambulatory Surg & Pain Mgt - James Island	Charleston	4		4	1085		1,085	271		*9*
Roper West Ashley Surgery Center	Charleston	5		5	2,382		2,382	476		*9*
Southeastern Spine Institute	Charleston	2		2	8,389		8,389	4,195		*10*
Surgery Center of Charleston	Charleston	1	1	2	2,554	1,350	3,904	2,554	1,350	
Trident Eye Surgery Center	Charleston	2		2	2,945		2,945	1,473		
Trident Surgery Center	Charleston	4		4	3,829		3,829	957		
West Ashley Endoscopy Center	Charleston		1	1						*11*
Colleton Ambulatory Surgery Center	Colleton	2	1	3	842	616	1,458	421	616	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	2,663		2,663	1,332		
TOTALS		168	75	243	170,115	118,958	289,073	1,146	1,440	

Ambulatory Surgical Facility (ASF) Footnotes

--- No data available for facility during reporting period.

1 CON issued to add 2 Endoscopy Suites for a total of 4, 12/10/09, SC-09-54. CON voided 7/28/10.

2 CON issued 10/22/07 to add 2 additional ORs and 1 Endoscopy Suite for a total of 9 ORs and 3 Endoscopy Suites, SC-07-55.

3 CON issued 10/22/07 to add 2 additional ORs for a total of 4 ORs, SC-07-54. Licensed for 4 ORs 1/15/10. Formerly Spartanburg Urology Surgicenter.

4 CON approved 1/23/04, appealed. CON issued 6/10/05 after dismissal of appeal, SC-05-40. CON issued 6/15/07 to add an additional OR for a total of 3 ORs and 2 Endoscopy Suites, SC-07-24; formerly Carolina Surgery Center. Licensed for the 3 ORs on 2/27/08; the 2 Endoscopy Suites were licensed 8/5/09.

5 CON denied to expand from 2 to 4 Endoscopy Suites 9/19/03; under appeal.

6 CON approved 2/26/07 for an ASF with 3 Endoscopy Suites restricted to gastroenterology procedures only; appealed. CON SC-08-18 issued 6/12/08. Licensed 2 of the Endoscopy Suites 6/26/09; licensed 3rd Endoscopy Suite 6/1/10.

7 CON issued 7/15/10 to add a 3rd OR, SC-10-22.

8 CON issued 8/24/09 to add 1 OR for a total of 3 ORs and 2 Endoscopy Suites, SC-09-41. New OR licensed 3/22/10.

9 CON issued 1/3/09 to transfer 2 ORs from Roper West Ashley Surgery Center to Roper St. Francis James Island Surgery Center, for a total of 3 ORs at Roper West Ashley Surgery Center and 4 ORs at Roper St. Francis James Island Surgery Center. License decreased from 5 ORs to 3 at Roper West Ashley effective 6/1/09. Roper St. Francis James Island licensed 9/30/09.

10 CON issued 6/12/08 after appeal, SC-08-17. Licensed 11/17/08.

11 CON approved 12/29/09; appealed. CON issued 5/3/10, SC-10-14.

B. Emergency Hospital Services:

All hospital emergency departments are sub-categorized into four levels of service from I to IV, with I being the highest level of care. These categories are based on modified TJC standards and adopted by the State EMS Advisory Council. Each facility must comply with the following paragraphs corresponding to their designated level of care. These standards do not constitute Certificate of Need criteria. All segments of the population should have basic emergency services available within 30 minutes one-way travel time.

Level I: offers comprehensive emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area. There is in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric/gynecologic, pediatric, and anesthesia services. Other specialty consultation is available within approximately 30 minutes; initial consultation through two-way voice communication is acceptable.

Level II: offers emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. The hospital's scope of services includes in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another organization when needed.

Level III: offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation is available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.

Level IV: offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest organization that is capable of providing needed services. The mechanism for providing physician coverage at all times is defined by the medical staff.

According to DHEC Health Licensing, the following facilities are considered to be freestanding emergency services (along with the hospital they are an extension of):

Moncks Corner Medical Center (Trident Medical Center) – Moncks Corner, Dorchester County
Seacoast Medical Center (Loris Community Hospital) – Little River, Horry County
South Strand Ambulatory Care Center (Grand Strand Regional) – Myrtle Beach, Horry County
Roper St. Francis Berkeley (Roper St. Francis) – Moncks Corner, Berkeley County
Roper St. Francis Northwoods (Roper St. Francis) – North Charleston, Charleston County

Certficate of Need Standards for Freestanding Emergency Services

(1) A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).

(2) All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

(3) Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, Section 613, will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

(4) An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.

(5) The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers and must specifically have an approved sprinkler system.

(6) The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Resource Availability; and
d. Financial Feasibility.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

C. Trauma Referral System:

The DHEC Division of Emergency Medical Services has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become so designated. The summary definitions below were derived from the American College of Surgeons criteria. The following is a brief description of the criteria for each of the three levels of Trauma Centers. Emergency departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.

Level I: The highest level of capability available. Generally speaking, this hospital has to have general surgery capability in-house at all times. Anesthesia capabilities are required to be in-house at all times, but this requirement may be met with CRNA's or anesthesiology chief residents. Orthopedic surgery, neurological surgery, and other surgical and medical specialties must be immediately available. Generally, these trauma centers will be attached to medical schools or will have residency programs because of the in-house requirements, since fourth year and senior trauma residents can help meet the requirements of the Level I criteria. The Level I Trauma Center also has the responsibility of providing education and outreach programs to other area hospitals and the public and must also conduct trauma-related research.

Level II: This hospital has extensive capability and meets the needs of most trauma victims. It is required to have general, neurological and orthopedic surgery available when the patient arrives. Anesthesiology capabilities are required to be in-house at all times, but this requirement may be met with CRNA's. Other surgical and medical specialties are required to be on-call and promptly available. These hospitals may develop local procedures for the surgeons being available in the Emergency Department when the patient arrives. The primary difference between Level I and II facilities is that the major surgical specialties are allowed to be on-call in Level II trauma centers but with the clear commitment to be in the Emergency Department when the patient arrives. Level II hospitals do not have the research requirements of a Level I trauma center.

Level III: This hospital is committed to caring for the trauma patient. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization, and also arrange for possible transfer of the patient to a facility that can provide definitive trauma care. These hospitals are required to have general surgery, anesthesia, and radiology on-call and promptly available. The general surgeon is required to be on-call and promptly available in the Emergency Department as the trauma team leader.

CHAPTER XII

LONG TERM CARE FACILITIES AND SERVICES

A. Nursing Facilities:

Nursing facilities provide inpatient care for convalescent or chronic disease residents who require nursing care and related medical services. Such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. Under www.scdhec.gov the licensing list of nursing facilities also denotes the facilities that have Alzheimer's units. For more specific detail about nursing facilities, refer to Regulation 61-17, Standards for Licensing Nursing Homes.

A ratio of 39 beds/1,000 population age 65 and over is used to project the need for 2013. Since the vast majority of patients utilizing nursing facilities are 65 years of age or older, only this segment of the population is used in the need calculations. A two-year projection is used because nursing facilities can be constructed and become operational in two years.

Certificate of Need Standards

1. Bed need is calculated on a county basis. Additional beds may be approved in counties with a positive bed need up to the need indicated.

2. When a county shows excess beds, additional beds will not be approved, except to allow an individual nursing facility to add some additional beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in three and/or four bed wards. A nursing facility may add up to 16 additional beds per nursing unit to create either 44 or 60 bed nursing units, regardless of the projected bed need for the county. The nursing facility must document how these additional beds will make a more economical unit(s).

3. Some Institutional Nursing Facilities (see Chapter XII E.) are dually licensed, with some beds restricted to residents of the retirement community and the remaining beds are available to the general public. The beds restricted to residents of the retirement community are not eligible to be certified for Medicare or Medicaid. Should such a facility have restricted beds that are inadvertently certified, the facility will be allowed to apply for a Certificate of Need to convert these beds to general nursing home beds, regardless of the projected bed need for that county.

The following pages depict the calculation of long-term care bed need and the current ratio of beds per thousand aged 65 and over by county. The following map depicts the number of additional beds needed or the number of excess beds (circled) by county.

Quality

CMS has established the 5-Star Quality Rating System for nursing facilities. It gives consumers the opportunity to see how different nursing facilities have rated on measurements of quality. The system gives each Medicare/Medicaid-participating nursing facility between 1-5 stars with 5 having the highest overall quality and 1 the lowest. This overall score is based on 3 components, each of which is also individually rated. These are:

a. Health inspections – from the past 3 years plus any complaint investigations.
b. Staffing ratios – the number of nursing hours of staff per patient per day, adjusted by the level of need of the patients.
c. Quality measures – 10 physical and clinical measures of patient care, such as incidence of bed sores and changes in mobility.

The system is accessible online and allows the user to compare multiple facilities at the same time. The URL is: http://www.medicare.gov/NHCompare

The Department may use the 5-Star data in evaluating a CON application for additional nursing facility beds at an existing facility.

Relative Importance of Project Review Criteria

The following project review criteria are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

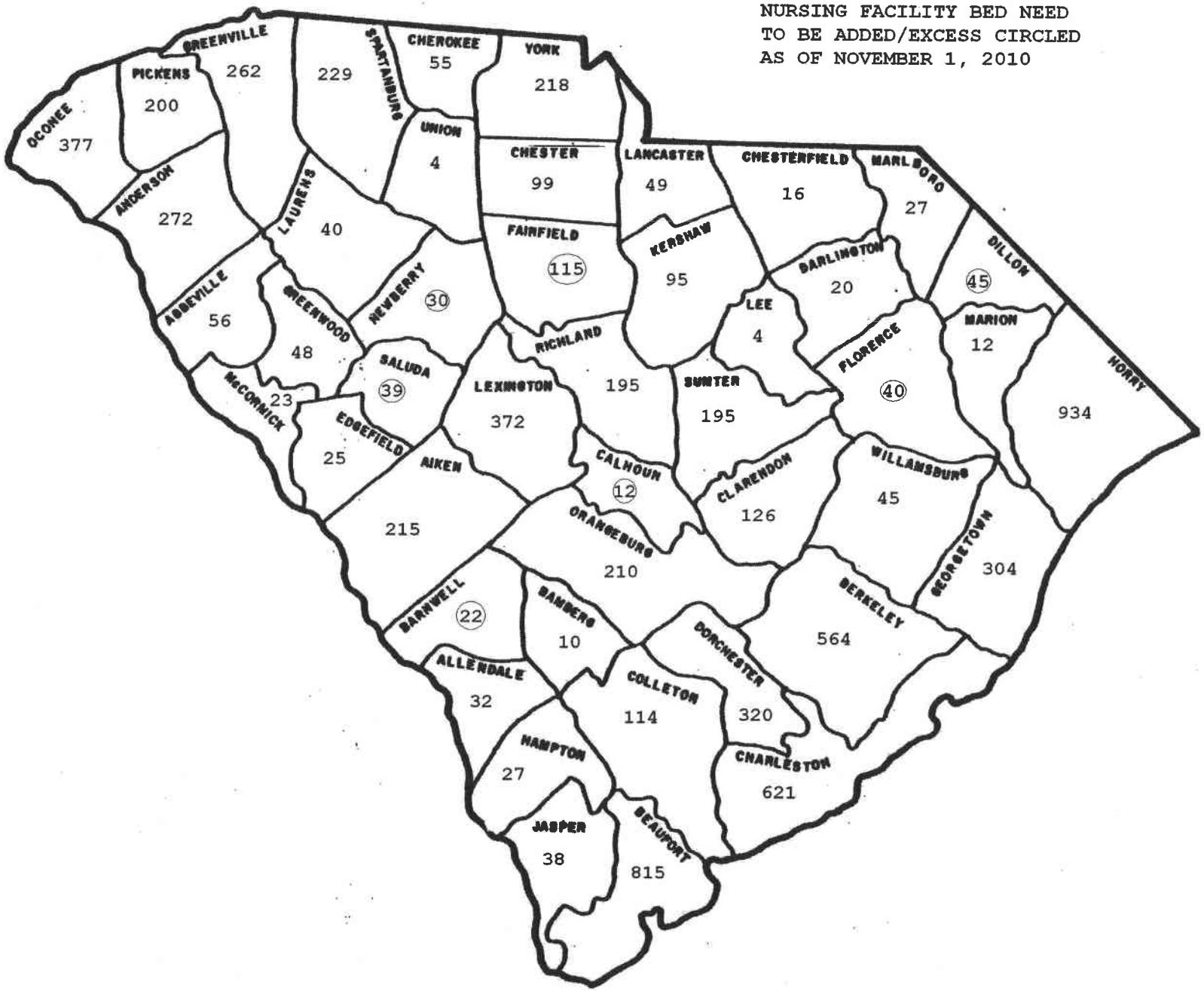
a. Compliance with the Need Outlined in this Section of the Plan;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

Because nursing facilities are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and at least one nursing facility is located in every county, no justification exists for approving additional nursing facilities or beds that are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since the Medicaid Program pays for approximately 65% of all nursing facility residents. This Plan projects the need for nursing facility beds by county. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

LONG TERM CARE BED NEED

		2013 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
	ANDERSON	27.76	1,083	811	272	272
	CHEROKEE	7.65	298	243	55	55
	GREENVILLE	54.18	2,113	1,851	262	262
	OCONEE	16.13	629	252	377	377
	PICKENS	16.33	637	437	200	200
	SPARTANBURG	38.67	1,508	1,279	229	229
	UNION	5.25	205	201	4	4
REGION I	TOTAL	165.97	6,473	5,074	1,399	1,399
	ABBEVILLE	4.40	172	116	56	56
	CHESTER	5.09	199	100	99	99
	EDGEFIELD	3.73	145	120	25	25
	FAIRFIELD	3.76	147	262	-115	
	GREENWOOD	10.31	402	354	48	48
	KERSHAW	8.68	339	244	95	95
	LANCASTER	8.64	337	288	49	49
	LAURENS	11.80	460	420	40	40
	LEXINGTON	33.23	1,296	924	372	372
	MCCORMICK	3.66	143	120	23	23
	NEWBERRY	6.30	246	276	-30	
	RICHLAND	39.09	1,525	1,330	195	195
	SALUDA	3.52	137	176	-39	
	YORK	23.36	911	693	218	218
REGION II	TOTAL	165.57	6,459	5,423	1,036	1,220
	CHESTERFIELD	6.16	240	224	16	16
	CLARENDON	7.12	278	152	126	126
	DARLINGTON	9.91	386	366	20	20
	DILLON	3.84	150	195	-45	
	FLORENCE	18.85	735	775	-40	
	GEORGETOWN	14.18	553	249	304	304
	HORRY	49.07	1,914	980	934	934
	LEE	3.19	124	120	4	4
	MARION	4.92	192	180	12	12
	MARLBORO	3.52	137	110	27	27
	SUMTER	15.97	623	428	195	195
	WILLIAMSBURG	5.88	229	184	45	45
REGION III	TOTAL	142.61	5,561	3,963	1,598	1,683
	AIKEN	25.45	993	778	215	215
	ALLENDALE	1.94	76	44	32	32
	BAMBERG	2.51	98	88	10	10
	BARNWELL	3.87	151	173	-22	
	BEAUFORT	36.56	1,426	611	815	815
	BERKELEY	23.57	919	355	564	564
	CALHOUN	2.78	108	120	-12	
	CHARLESTON	48.94	1,909	1,288	621	621
	COLLETON	6.30	246	132	114	114
	DORCHESTER	17.21	671	351	320	320
	HAMPTON	3.35	131	104	27	27
	JASPER	3.24	126	88	38	38
	ORANGEBURG	15.46	603	393	210	210
REGION IV	TOTAL	191.18	7,457	4,525	2,932	2,966
STATEWIDE TOTALS		665.33	25,950	18,985	6,965	7,268

NURSING FACILITY BED NEED
TO BE ADDED/EXCESS CIRCLED
AS OF NOVEMBER 1, 2010



COUNTY	2013 POP (000s 65+)	NURSING FACILITY BEDS	BEDS PER 1,000 POP	RANK
BERKELEY	23.57	355	15.06	1
OCONEE	16.13	252	15.62	2
BEAUFORT	36.56	611	16.71	3
GEORGETOWN	14.18	249	17.56	4
CHESTER	5.09	100	19.65	5
HORRY	49.07	980	19.97	6
DORCHESTER	17.21	351	20.40	7
COLLETON	6.30	132	20.95	8
CLARENDON	7.12	152	21.35	9
ALLENDALE	1.94	44	22.68	10
ORANGEBURG	15.46	393	25.42	11
CHARLESTON	48.94	1,288	26.32	12
ABBEVILLE	4.40	116	26.36	13
PICKENS	16.33	437	26.76	14
SUMTER	15.97	428	26.80	15
JASPER	3.24	88	27.16	16
LEXINGTON	33.23	924	27.81	17
KERSHAW	8.68	244	28.11	18
ANDERSON	27.76	811	29.21	19
YORK	23.36	693	29.67	20
AIKEN	25.45	778	30.57	21
HAMPTON	3.35	104	31.04	22
MARLBORO	3.52	110	31.25	23
WILLIAMSBURG	5.88	184	31.29	24
CHEROKEE	7.65	243	31.76	25
EDGEFIELD	3.73	120	32.17	26
MCCORMICK	3.66	120	32.79	27
SPARTANBURG	38.67	1,279	33.07	28
LANCASTER	8.64	288	33.33	29
RICHLAND	39.09	1,330	34.02	30
GREENVILLE	54.18	1,851	34.16	31
GREENWOOD	10.31	354	34.34	32
BAMBERG	2.51	88	35.06	33
LAURENS	11.80	420	35.59	34
CHESTERFIELD	6.16	224	36.36	35
MARION	4.92	180	36.59	36
DARLINGTON	9.91	366	36.93	37
LEE	3.19	120	37.62	38
UNION	5.25	201	38.29	39
FLORENCE	18.85	775	41.11	40
CALHOUN	2.78	120	43.17	41
NEWBERRY	6.30	276	43.81	42
BARNWELL	3.87	173	44.70	43
SALUDA	3.52	176	50.00	44
DILLON	3.84	195	50.78	45
FAIRFIELD	3.76	262	69.68	46
	665.35	18,985	28.53	

B. Medicaid Nursing Home Permits:

Beginning July 1, 1988, nursing facilities that wish to continue to serve Medicaid residents must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing facility may provide, and the nursing facility must provide within 10 percent of this number of days of care. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

Medicaid Patient Days and Medicaid Beds Requested and Authorized:

Year	# Days Requested	Beds	# Days Authorized	Beds	# Days Difference
1988-1989	3,032,839	8,309	2,971,811	8,142	61,028
1989-1990	3,644,248	9,984	3,644,248	9,984	0
1990-1991	3,709,814	10,163	3,659,965	10,028	49,849
1991-1992	3,856,833	10.567	3,659,965	10,028	196,868
1992-1993	3,976,576	10,895	3,806,382	10,429	170,194
1993-1994	4,012,359	10,993	3,856,382	10,566	155,977
1994-1995	4,023,690	11,024	3,892,882	10,665	130,808
1995-1996	3,969,681	10,876	3,892,882	10,665	76,799
1996-1997	4,072,519	11,158	4,002,382	10,965	70,137
1997-1998	4,119,753	11,287	4,097,282	11,225	22,471
1998-1999	4,265,182	11,685	4,265,182	11,685	0
1999-2000	4,367,134	11,965	4,341,832	11,895	25,302
2000-2001	4,420,522	12,111	4,378,332	11,995	42,190
2001-2002	4,473,170	12,255	4,275,998	11,715	197,172
2002-2003	4,340,158	11,891	4,205,553	11,522	134,605
2003-2004	4,304,160	11,792	4,205,553	11,522	98,607
2004-2005	4,294,977	11,767	4,205,553	11,522	89,424
2005-2006	4,291,812	11,758	4,205,553	11,522	86,259
2006-2007	4,283,209	11,735	4,205,553	11,522	77,656
2007-2008	4,263,785	11,682	4,205,553	11,522	58,232
2008-2009	4,231,047	11,592	4,205,553	11,522	25,494
2009-2010	4,215,522	11,549	4,205,553	11,522	9,969
2010-2011	4,217,584	11,555	4,205,553	11,522	12,031

C. Community Long Term Care (CLTC) Program:

The South Carolina Community Long Term Care Project (CLTC) provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing facility placement under the Medicaid program. It also provides the following community-based services for participants who prefer to receive care in the community rather than institutional care:

a. Personal Care;
b. Environmental Modifications;
c. Home-Delivered Meals;

d. Adult Day Health Care (ADHE);
e. Respite Care;
f. Personal Emergency Response System (PERS);
g. Durable Medical Equipment;
h. Nursing Services; and
i. Case Management.

DHHS operates three home and community-based Medicaid waiver programs through the CLTC program. Community Choices was funded for 12,000 slots for FY 07-08; the other waivers serve 1,000 persons with HIV disease and approximately 30 adults who are dependent upon mechanical ventilation. The PACE program is jointly funded by Medicare and provides primary and long-term care services to participants age 55 and older who meet the State's nursing facility level of care. The Palmetto SeniorCare (PSC) Program operates five PACE Centers in Richland and Lexington Counties and served 440 participants during FY 2007. A second PACE site began operation in March 2008 operated by The Oaks CCRC in Orangeburg. DHHS is also participating in a federal initiative called Money Follows the Person, which allows people who have been in a nursing facility for at least six months to transition back to the community.

D. Mental Retardation Facilities:

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed.

The South Carolina Department of Disabilities and Special Needs (DDSN) has reduced the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds have been developed for those persons from the regional centers and those on the residential services waiting list. These beds represent the continuum of programs, which includes community residences, supervised living programs, and community training homes. These programs enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in. DDSN also operates three home and community-based Medicaid waiver programs for the following target groups: Mental Retardation and Related Disabilities, Head and Spinal Cord Injuries, and Pervasive Developmental Disorders.

E. Institutional Nursing Facility (Retirement Community Nursing Facility):

An institutional nursing facility means a nursing facility (established within the jurisdiction of a larger non-medical institution) that maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. A bed need for this category has been established in order to provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program that has documented that the entire complex is one inseparable project.

To be considered under this special bed category, the following criteria must be met:

(1) The nursing facility must be a part of and located on the campus of the retirement community.

(2) It must restrict admissions to campus residents.

(3) The facility may not participate in the Medicaid program.

There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home," and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, a generally accepted ratio of nursing facility beds to retirement beds is 1:4. However, this ratio may high for a newly established retirement center as new residents are typically not in need of nursing facility care as soon as the facility is licensed. The nursing facility could operate at low utilization for the first several years.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Need for the Proposed Project;
b. Economic Consideration; and
c. Health System Resources.

Because Institutional Nursing Facility Beds are used solely by the residents of the retirement community, there is no justification for approving this type of nursing facility unless the need can be documented by the retirement center. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or facilities.

F. Swing Beds:

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina. However, the hospital must be certified to participate in Medicare.

The Social Security Act (Section 1883(a)(1), [42 U.S.C. 1395tt] permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. The hospital must be located in a rural area and have fewer than 100 beds. The Code of Federal Regulations (CFR) section 42 details the other specific program requirements

Medicare Part A covers the services furnished in a swing bed hospital under the SNF PPS. The PPS classifies residents into one of 44 categories for payment purposes. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient for a stay of at least three consecutive days, although it does not have to be from the same hospital as the swing bed. Typical medical criteria include daily physical, occupational and/or speech therapy, IV or nutritional therapy, complex wound treatment, pain management, and end-of-life care.

The following hospitals in South Carolina participated in the swing bed program during 2009:

Hospital		Swing Beds	Admissions	Patient Days	Average Census
Abbeville Area Medical Ctr.		25	43	422	1.2
Allendale County Hospital		15	78	3,371	9.2
Bamberg County Memorial	*1*	24			
Chesterfield General		48	81	520	1.4
Coastal Carolina		10	16	87	0.3
Edgefield Co. Hospital		25	130	1,075	2.9
Fairfield Memorial	*1*	25			
Marlboro Park Hospital		6	61	315	0.9
McLeod-Darlington		24	71	6,296	17.2
Wallace Thompson	*1*	12			
Williamsburg Regional	*1*	10			
TOTALS		224	480	12,086	33.0

1 Participates in the program but did not use the beds in 2009.

G. Hospice Facilities and Hospice Programs:

Hospice is a centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including, but not limited to home, outpatient and inpatient services provided directly or through written agreement. Inpatient services include, but are not limited to, services provided by a hospice in a licensed hospice facility.

A Hospice Facility means an institution, place or building licensed by the Department to provide room, board and appropriate hospice care on a 24-hour basis to individuals requiring such services pursuant to the orders of a physician.

A Hospice Program means an entity licensed by the Department that provides appropriate hospice care to individuals as described in the first paragraph above, exclusive of the services provided by a hospice facility.

The existing and approved inpatient hospices in South Carolina are listed on the following page.

Certificate of Need Standards

1. A Certificate of Need is only required for an Inpatient Hospice Facility; it is not required for the establishment of a Hospice Program.

2. An Inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program.

3. The applicant must document the need for the facility and justify the number of inpatient beds that are being requested.

4. The proposed facility must consider the impact on other existing inpatient hospice facilities.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Community Need Documentation;
d. Acceptability;
e. Financial feasibility; and
f. Staff Resources.

Ninety-nine licensed Hospice Programs exist with at least one licensed hospice serving every county in the state. Additional information may be found at http://www.scdhec.net/health/hrreg.htm. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

INPATIENT HOSPICES, 2009 DATA

NAME OF FACILITY	COUNTY	LICENSED BEDS	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
REGION I						
CALLIE & JOHN RAINEY HOSPICE HOUSE	ANDERSON	32	659	8,456	32	72.4%
MCCALL HOSPICE HOUSE OF GREENVILLE	GREENVILLE	30	438	8,339	30	76.2%
OCONEE MEMORIAL HOSPICE FOOTHILLS	OCONEE	15	247	3,270	15	59.7%
HOSPICE HOUSE OF CAROLINA FOOTHILLS	SPARTANBURG	12	97	1,245	12	28.4%
SPARTANBURG REG HEALTHCARE HOSPICE	SPARTANBURG	15	613	4,847	15	88.5%
TOTAL		104	2,054	26,157	104	68.9%
REGION II						
HOSPICE HOUSE OF HOSPICECARE PIEDMONT	GREENWOOD	15	440	2,842	15	51.9%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE	LAURENS	12	114	1,314	12	30.0%
ASCENSION HOUSE	RICHLAND	14	312	2,573	14	50.4%
HOSPICE AND COMMUNITY CARE HOUSE	YORK	16	250	3,020	16	51.7%
TOTAL		57	1,116	9,749	57	46.9%
REGION III						
MCLEOD HOSPICE HOUSE *1*	FLORENCE	24	469	3,708	12	84.7%
TIDELANDS COMMUNITY HOSPICE HOUSE	GEORGETOWN	12	206	1,763	12	40.3%
AGAPE HOSPICE HOUSE OF HORRY COUNTY *2*	HORRY	0	0	0	---	---
TOTAL		36	675	5,471	24	62.5%
REGION IV						
HOSPICE CTR HOSPICE OF CHARLESTON	CHARLESTON	20	517	4,935	20	67.6%
TOTAL		20	517	4,935	20	67.6%
STATEWIDE TOTAL		**217**	**4,362**	**46,312**	**205**	**61.9%**

1 CON APPROVED 2/23/10 TO ADD 12 BEDS FOR A TOTAL OF 24.

2 CON ISSUED 7/15/10 TO CONVERT THE INPATIENT HOSPICE BEDS TO NURSING HOME BEDS.

H. Home Health

1. Home Health Agencies:

Home Health Agency means a public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services. Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (f) below, in a place of temporary or permanent residence used as the individual's home as follows:

Part-time or intermittent skilled nursing care as ordered by a physician or podiatrist and provided by or under the supervision of a registered nurse and at least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services; (c) home health aide services; (d) other therapeutic services; (e) medical supplies as indicated in the treatment plan and the use of medical appliances, to include durable medical equipment and (f) any of the above items and services provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing home or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items/services cannot readily be made available to the individual in his/her home, or which are furnished at one of the above facilities while the patient is there to receive such items or services. Transportation of the individual in connection with any such items or services is not included.

The average mix of home health visits by type of service during FY 2009 for the home health agencies in South Carolina were:

Total Visits	2,017,737
Nursing Visits	43.82%
Home Health Aide Visits	8.22%
Physical Therapy Visits	34.78%
Medical Social Worker Visits	1.81%
Speech Therapy Visits	1.55%
Occupational Therapy Visits	9.00%
Other	0.84%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Under the Balanced Budget Act of 1997, Medicare changed to a Prospective Payment System (PPS) for home health services. Patients are assessed and assigned to one of 80 Home Health Resource Groups (HHRGs); agencies then receive a fixed payment for a 60-day episode of care, regardless of the number of visits provided. As a result, the number of visits per patient has decreased from 45.7 in 1997 to 20.9 in 2009. In 2007, CMS revised its policy on "case mix," which was expected to make a nearly 12%

reduction in the national 60-day standardized payment rate by 2011 and decrease home health expenditures by $7 billion over that time.

Of the patients currently receiving home health services, less than 2% are age 14 and under, approximately 33% are age 15-64 and the rest are age 65 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Certificate of Need Standards

1. An applicant must propose home health services to cover the geographic area of an entire county and agree to serve residents throughout the entire county.

2. A separate application is required for each county in which services are to be provided.

3. It is recommended that an application for a new home health agency should contain letters of support from physicians in the proposed service area.

4. The need methodology creates statewide use rates for four population groups (0-14, 15-64, 65-74, 75+) based on 2009 utilization data; 75% of these rates are applied against the projected 2011 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2009 and multiplies them by the population growth factor to project the number of patients to be served by the existing home health agencies in the county for 2011. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of greater than 100 patients projected to be in need, then another agency could be approved for that county.

5. Before an application for a new home health agency can be accepted for filing, all existing agencies in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The data will not be prorated or projected into the future but based on actual utilization.

6. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.

7. The applicant must document that it can serve at least 50 patients annually in each county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to fewer than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

Quality

CMS initiated a national home health quality improvement campaign in January 2010. The Home Health Quality Improvement (HHQI) initiative is designed to reduce avoidable hospitalizations and improve medication management. The campaign will provide resources and best practice education to participating HHAs. The South Carolina Home Care & Hospice Association (SCHCA) is serving as the Local Area Network for Excellence (LANE) to create campaign awareness and recruit participants.

While this is a voluntary campaign, the Department encourages all licensed Home Health Agencies to participate.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing CON applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Acceptability;
c. Distribution (Accessibility);
d. Medically Underserved Groups;
e. Record of the Applicant; and
f. Financial Feasibility.

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing service.

2. Pediatric Home Health Agencies:

Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the above criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving

children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

Certificate of Need Standards

1. A separate CON application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.

2. The applicant must document that no other agency offers this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.

3. Continuing Care Retirement Community Home Health Agencies:

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

1. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;

2. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and

3. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

Staff from other areas of the continuing care retirement community may deliver the home health services, but at no time may staffing levels in any area of the continuing care retirement community fall below minimum licensing standards or impair the services provided. If the continuing care retirement community includes charges for home health services in its base contract, it is prohibited from billing additional fees for those services. Continuing care retirement communities certified for Medicare or Medicaid, or both, must comply with government reimbursement requirements concerning charges for home health services. The continuing care retirement community shall not bill in excess of its costs. These costs will be determined on non-facility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, these facilities are not counted in the county need projections.

HOME HEALTH METHODOLOGY

County	Projected Pop 2011 Age 0-14	2011 Estimated Pts Age 0 - 14	Projected Pop 2011 Age 15-64	2011 Estimated Pts Age 15 - 64	Projected Pop 2011 Age 65-74	2011 Estimated Pts Age 65 - 74	Projected Pop 2011 Age 75+	2011 Estimated Pts Age 75+	Total Estimated 2011 Patients	2009 Actual Patients	Population Growth Factor	Total Projected 2011 Patients	2011 Unmet (Need)/ Surplus	Need at 100 Patients	New Agency Approved Since 12/31/08	New Agency Can be Approved
Abbeville	5,530	6	18,020	143	2,380	194	1,870	153	495	831	1.012	841	346	-----	-----	-----
Aiken	30,520	31	111,530	883	13,680	1,117	10,210	834	2,864	2,512	1.025	2,575	(289)	YES	YES	-----
Allendale	2,530	3	7,660	61	1,040	85	780	64	212	112	1.005	112	(100)	YES	-----	YES
Anderson	35,330	35	120,130	951	15,740	1,285	10,730	876	3,148	3,357	1.018	3,419	271	-----	-----	-----
Bamberg	2,990	3	10,280	81	1,440	118	940	77	279	261	0.990	258	(20)	-----	-----	-----
Barnwell	4,940	5	17,070	135	2,060	168	1,550	127	435	464	1.016	472	37	-----	-----	-----
Beaufort	22,270	22	94,010	744	19,790	1,616	13,130	1,072	3,455	3,231	1.038	3,354	(101)	YES	-----	YES
Berkeley	34,880	35	113,830	901	13,190	1,077	7,810	638	2,651	2,514	1.027	2,582	(69)	-----	-----	-----
Calhoun	2,790	3	11,130	88	1,640	134	970	79	304	271	1.022	277	(27)	-----	-----	-----
Charleston	60,100	60	224,480	1,777	27,140	2,216	18,510	1,512	5,565	8,970	1.013	9,087	3,522	-----	-----	-----
Cherokee	12,230	12	38,970	308	4,380	358	2,910	238	916	1,251	1.022	1,279	363	-----	-----	-----
Chester	7,360	7	23,420	185	2,920	238	1,980	162	593	831	1.010	839	246	-----	-----	-----
Chesterfield	9,120	9	29,630	235	3,630	296	2,180	178	718	880	1.012	891	172	-----	-----	-----
Clarendon	6,240	6	22,120	175	4,170	341	2,360	193	715	625	1.016	635	(80)	-----	-----	-----
Colleton	8,890	9	27,120	215	3,710	303	2,210	180	707	1,113	1.016	1,131	424	-----	-----	-----
Darlington	14,290	14	45,970	364	5,810	474	3,470	283	1,136	1,304	1.008	1,314	178	-----	-----	-----
Dillon	6,580	7	20,080	159	2,240	183	1,370	112	460	724	0.999	723	263	-----	-----	-----
Dorchester	22,470	22	79,330	628	9,210	752	6,170	504	1,906	2,424	1.031	2,499	593	-----	-----	-----
Edgefield	4,640	5	19,760	156	2,090	171	1,290	105	437	312	1.028	321	(116)	YES	-----	YES
Fairfield	5,070	5	16,650	132	2,080	170	1,360	111	418	531	1.012	537	120	-----	-----	-----
Florence	26,650	27	91,150	721	10,430	852	7,150	584	2,184	2,887	1.013	2,925	741	-----	-----	-----
Georgetown	10,430	10	39,110	310	8,050	657	4,890	399	1,377	1,952	1.022	1,995	618	-----	-----	-----
Greenville	81,890	82	292,670	2,316	30,410	2,483	20,940	1,710	6,592	8,721	1.023	8,922	2,330	-----	-----	-----
Greenwood	14,590	15	47,240	374	5,710	466	4,150	339	1,194	2,125	1.015	2,157	963	-----	-----	-----
Hampton	4,470	4	15,240	121	1,890	154	1,270	104	383	459	1.016	466	83	-----	-----	-----
Horry	35,690	36	162,930	1,290	27,950	2,282	17,110	1,397	5,005	6,475	1.040	6,734	1,729	-----	-----	-----
Jasper	4,080	4	16,270	129	1,750	143	1,230	100	376	392	1.029	403	27	-----	-----	-----
Kershaw	11,610	12	39,870	316	4,850	396	3,310	270	994	1,383	1.025	1,418	424	-----	-----	-----
Lancaster	12,620	13	43,490	344	5,190	424	3,000	245	1,026	1,584	1.011	1,602	576	-----	-----	-----
Laurens	14,100	14	52,860	418	6,590	538	4,530	370	1,341	1,773	1.023	1,814	473	-----	-----	-----
Lee	4,200	4	13,880	110	1,640	134	1,400	114	362	297	1.008	299	(63)	-----	-----	-----
Lexington	48,560	49	177,250	1,403	17,940	1,465	12,750	1,041	3,958	5,140	1.032	5,304	1,347	-----	-----	-----
Marion	7,470	7	24,260	192	2,950	241	1,760	144	584	783	1.009	790	206	-----	-----	-----
Marlboro	5,810	6	18,150	144	2,140	175	1,240	101	425	568	0.991	563	137	-----	-----	-----
McCormick	1,180	1	7,000	55	2,120	173	1,130	92	322	312	1.022	319	(3)	-----	-----	-----
Newberry	7,390	7	25,440	201	3,470	283	2,510	205	697	875	1.014	887	190	-----	-----	-----
Oconee	13,060	13	48,210	382	9,240	755	5,830	476	1,625	2,019	1.024	2,066	441	-----	-----	-----
Orangeburg	19,120	19	63,770	505	8,540	697	5,990	489	1,710	2,739	1.011	2,769	1,059	-----	-----	-----
Pickens	22,500	23	90,860	719	9,080	741	6,310	515	1,998	2,430	1.026	2,493	495	-----	-----	-----
Richland	65,270	65	246,910	1,954	21,690	1,771	14,570	1,190	4,981	6,283	1.016	6,384	1,404	-----	-----	-----
Saluda	3,740	4	13,140	104	1,880	154	1,480	121	382	350	1.014	355	(27)	-----	-----	-----
Spartanburg	54,740	55	191,940	1,519	22,050	1,801	14,490	1,183	4,558	5,615	1.019	5,722	1,164	-----	-----	-----
Sumter	25,970	26	75,840	600	8,570	700	6,500	531	1,857	2,649	1.014	2,686	829	-----	-----	-----
Union	5,760	6	18,570	147	2,760	225	2,360	193	571	766	0.996	763	192	-----	-----	-----
Williamsburg	7,630	8	23,660	187	3,350	274	2,140	175	643	914	0.998	912	269	-----	-----	-----
York	36,750	37	136,820	1,083	13,120	1,071	8,590	701	2,892	3,997	1.031	4,122	1,230	-----	-----	-----
SUM TOTAL	**844,050**	**844**	**3,027,720**	**23,964**	**371,700**	**30,353**	**248,430**	**20,287**	**75,448**	**96,006**	**1.021**	**98,016**	**22,568**			

HOME HEALTH UTILIZATION, 1980-2009

YEAR	PATIENTS SERVED
1980	17,120
1981	18,021
1982	19,751
1983	24,013
1984	28,511
1985	30,360
1986	21,012
1987	30,004
1988	31,230
1989	32,727
1990	36,827
1991	41,912
1992	49,035
1993	55,551
1994	65,754
1995	77,214
1996	86,070
1997	88,711
1998	86,123
1999	83,969
2000	78,542
2001	77,869
2002	84,192
2003	81,708
2004	82,971
2005	81,754
2006	82,897
2007	89,851
2008	91,724
2009	97,112

Home Health Agency Utilization 2009

Agency	Counties Served	Persons Served	Total Visits
Alere Womens & Childrens-Midlands *1* (may serve obstetrical patients only)	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	360	570
Alere Womens & Childrens-Piedmont *2* (may serve obstetrical patients only)	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	439	641
Amedysis Home Health of Camden	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	1,103	21,738
Amedysis Home Health of Charleston	Berkeley, Charleston & Dorchester	3,470	77,798
Amedysis Home Health of North Charleston	Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,435	89,302
Amedysis Home Health of Clinton	Abbeville, Greenville, Greenwood & Laurens	1,940	45,487
Amedysis Home Health of Conway	Horry	1,395	34,733
Amedysis Home Health Georgetown	Georgetown & Williamsburg	1,868	32,890
Amedysis HH Georgetown East	Georgetown & Williamsburg	198	3,068
Amedisys Home Health Hilton Head	Beaufort & Jasper	1,113	27,707
Amedysis Home Health of Lexington	Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	5,721	128,285
Amedysis Home Health Myrtle Beach	Horry	1,179	20,392
AnMed Health Home Health	Anderson	1,134	27,461
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	186	5,725
Bethea Home Health (may serve retirement community only)	Darlington	34	27,734
Care One Home Health	Beaufort, Hampton & Jasper	976	24,056
CarePro Home Health	Richland & Sumter	598	13,362
Caring Neighbors Home Health	Fairfield	253	5,709
Carolina Home Health Care	Lexington & Richland	1,624	35,202

Carolina Home Health Care Charleston	*3*	Berkeley, Charleston & Dorchester		
Carolina Home Health Care Greenville (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)		Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	2,845	75,968
Carolinas Home Health	*4*	Darlington, Dillon, Florence & Marlboro	1,351	28,119
Chesterfield Visiting Nurses Services		Chesterfield, Darlington & Marlboro	444	9,255
Clarendon Memorial Home Health		Clarendon	383	5,079
Clemson Area Retirement Ctr HH (may serve retirement community only)		Pickens	18	4,384
Covenant Place Home Health (may serve retirement community only)	*5*	Sumter		
Cypress Club Home Health Agency (may serve retirement community only)		Beaufort	65	3,437
DHEC Region 1 Home Health		Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee & Saluda	862	20,602
DHEC Region 2 Home Health West		Greenville & Pickens	603	6,615
DHEC Region 2 Home Health East		Cherokee, Spartanburg & Union	415	8,737
DHEC Region 3 Home Health		Chester, Fairfield, Lancaster, Lexington, Newberry, Richland & York	932	14,211
DHEC Region 4 Home Health East		Chesterfield, Darlington, Dillon, Florence, Marion & Marlboro	1,876	33,153
DHEC Region 4 Home Health West		Clarendon, Kershaw, Lee & Sumter	616	13,749
DHEC Region 5 Home Health		Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	732	13,153
DHEC Region 6 Home Health		Georgetown, Horry & Williamsburg	499	6,525
DHEC Region 7 Home Health		Berkeley, Charleston & Dorchester	647	15,520
DHEC Region 8 Home Health		Colleton & Hampton	407	5,952
Florence Visiting Nurses Services		Dillon, Florence, Lee & Marion	306	7,535
Franklin C. Fetter Home Health Agency		Charleston	129	3,984
Greenville Hospital System HHA		Greenville & Pickens	1,869	31,161
Health Related Home Care		Abbeville, Greenwood, Laurens, McCormick & Saluda	1,479	47,534
HomeCare of HospiceCare Piedmont (may only serve terminally ill patients in Saluda County)		Abbeville, Greenwood, Laurens, McCormick & Saluda	24	466

Home Care of Lancaster	Lancaster	1,331	40,641
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	947	20,895
Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,807	43,857
Hospice Care of Low Country Home Health (may serve terminally ill patients only)	Beaufort & Jasper	27	413
Incare Home Health	Georgetown & Horry	1,820	24,895
Interim HealthCare of Greenville	Anderson, Cherokee, Greenville, Oconee, Pickens & Spartanburg	8,732	151,848
Interim HealthCare of Rock Hill	York	1,649	23,911
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester & Georgetown	1,849	32,097
Island Health Care	Beaufort	1,440	31,359
Kershawhealth Home Health	Kershaw	836	15,945
Laurel Crest Home Health Agency (may serve retirement community only)	Lexington		
Liberty Home Care - Aiken	Aiken	365	7,070
Liberty Home Care - Bennettsville	Marlboro	288	4,286
Liberty Home Care - Myrtle Beach	Horry	946	14,539
Live Long Wellcare of Brightwater ***6*** (may serve retirement community only)	Horry		
Live Long Wellcare Litchfield ***7*** (may serve retirement community only)	Georgetown		
Live Long Wellcare Summit Hills ***8*** (may serve retirement community only)	Spartanburg		
McLeod Home Health	Darlington, Dillon, Florence, Lee & Marion	3,047	44,815
Methodist Manor Home Health ***9*** (may serve retirement community only)	Florence		
Methodist Oaks Campus Home Health (may serve retirement community only)	Orangeburg		
NHC HomeCare - Aiken	Aiken	561	19,773
NHC HomeCare - Greenwood	Greenwood	272	12,454
NHC HomeCare - Laurens	Greenville & Laurens	995	37,967
NHC HomeCare - LowCountry ***10***	Berkeley & Dorchester	520	11,807
NHC HomeCare - Midlands ***11***	Lexington & Richland	1,180	21,463

NHC HomeCare - Piedmont	***12***	York	834	17,831
Neighbors Care Home Health Agency		Chester	379	9,333
Oconee Memorial Home Health		Anderson, Oconee & Pickens	699	21,495
Palmetto Health HomeCare (terminally ill Bamberg Co. patients only)		Bamberg, Lexington & Richland	1,423	32,039
Pediatric Home Health (restricted to pediatric patients only)	***13***	Berkeley, Charleston & Dorchester		
PHC Home Health		Charleston	651	18,384
Roper-St. Francis Home Health Care		Berkeley, Charleston & Dorchester	2,917	57,709
Seabrook Wellness & Home Health Care (may serve retirement community only)		Beaufort	34	1,976
Sea Island Home Health		Charleston & Colleton	76	3,123
Spartanburg Reg Med Ctr Home Health		Spartanburg	1,833	39,019
St. Francis Hospital Home Care		Anderson, Greenville, Pickens & Spartanburg	2,781	42,315
Still Hopes Solutions for Living at Home (may serve retirement community only)		Lexington		
Total Care Home Health		Cherokee, Chester, Union & York	3,030	66,237
Total Care - Coastal		Georgetown, Horry & Williamsburg	1,334	29,507
Tri-County Home Health Care	***14***	Aiken, Lexington, Richland, Saluda & Sumter	3,819	66,563
Trinity Home Service Home Health		Aiken, Barnwell & Edgefield	914	16,428
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)		Clarendon, Lee & Sumter	980	15,349
University Home Health North Augusta		Aiken & Edgefield	1,129	18,913
VNA of Greater Bamberg		Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	640	19,440
Wesley Commons Home Health Care (may serve retirement community only)		Greenwood	32	4,479
Westminster Campus Home Health (may serve retirement community only)		York	19	563
			97,112	2,017,737

Home Health Agency Footnotes

1 Name changed, formerly Matria Healthcare-Midlands.
2 Name changed, formerly Matria Healthcare-Piedmont.
3 Formerly Hospice of Charleston Home Health Agency.
4 Name changed, formerly Home Health Services of Carolina Hospital System.
5 Licensed 5/4/10 to serve the residents of the retirement community.
6 Licensed 9/16/09. Previously Brightwater Home Health Agency.
7 Formerly Lakes of Litchfield.
8 Licensed 5/14/09. Formerly Summitt Hills Home Health Agency.
9 Licensed 2/12/10.
10 Formerly Home Health of South Carolina – Low Country
11 Formerly Home Health of South Carolina – Midlands
12 Formerly Home Health of South Carolina
13 CONs issued for HHA restricted to pediatric patients only, 12/10/09, SC-09-50, SC-09-51, SC-09-52. Licensed 3/2/10.
14 CON approved for Aiken County; appealed.

STATE SUMMARY

PROGRAM OF EACH REGION

Regional Need and Narrative
Regional Summary and Program
Inventory of Inpatient Facilities
Inventory of Emergency Facilities and Trauma Centers

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes that have occurred since the previous Plan are explained by a footnote. The numbers of existing and approved beds are summarized by region. The inventory of beds and facilities was current as of November 1, 2010.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE FISCAL YEAR: 2009

1. Statewide Health Facilities: The medical facilities serving the entire state are included in this section. These facilities tend to serve restricted use population groups as well as populations with unique needs. Due to fluctuations in the population groups served by these facilities, these types of facilities will be evaluated on an individual basis should an expansion of services or creation of new services or facilities be requested. This Plan recognizes that the needs of the Department of Mental Health and Department of Disabilities and Special Needs may change as the client population changes, since they cannot refuse any client assigned to them by the courts. Therefore, renovation, replacement, and expansion of component programs should be allowed. Because of special conditions placed on the Department of Juvenile Justice by the courts, their patients/clients must be placed in the appropriate alternative setting. Since these patients/clients are to be placed elsewhere within the State system, the State agency responsible for their care should be allowed to develop these alternative programs by contracting with a private provider, by allowing a private provider to construct a facility for these patients/clients or by the conversion/ construction of their own facilities. Facilities that have a contract with the State to serve such individuals will be approved and counted in the statewide category. Facilities owned and operated by the Department of Mental Health and the Department of Disabilities and Special Needs are exempt from Certificate of Need review except an addition of one or more beds to the total number of beds existing as of July 1, 1988. The Department of Mental Health had 3,720 and the Department of Disabilities and Special Needs had 3,100 beds. The William J. McCord Adolescent Treatment Facility received a CON on 7/16/10 to convert to a specialized hospital restricted primarily to the provision of alcohol and drug abuse treatment for adolescents.

2. All changes affecting the Statewide Health Facilities have been fully annotated in the inventory.

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
HOSPITALS:								
THE CITADEL INFIRMARY		CHARLESTON	CHARLESTON	ST	38	38		
LIEBER CORRECTIONAL INST INFIRMARY		DORCHESTER	RIDGEVILLE	ST	10	10		
SHRINERS HOSPITAL FOR CHILDREN		GREENVILLE	GREENVILLE	NPA	50	50	1,180	3,607
W.J. BARGE MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	79	90		
LEE CORRECTIONAL INSTITUTE INF		LEE	BISHOPVILLE	ST	20	20		
SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30	526	302
COLUMBIA REGIONAL CARE CENTER		RICHLAND	COLUMBIA	PROP	196	196	242	62,677
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	11	11		
KIRKLAND CORRECTIONAL INFIRMARY		RICHLAND	COLUMBIA	ST	24	24		
WILLOW LANE INFIRMARY		RICHLAND	COLUMBIA	ST	8	8		
CHILDREN'S HABILITATION CENTER		SPARTANBURG	SPARTANBURG	ST	22	22	299	299
TOTAL					**450**	**461**	**2,247**	**66,885**
MENTAL HOSPITALS:								
PATRICK B HARRIS PSYCHIATRIC		ANDERSON	ANDERSON	ST	200	200	1,142	51,678
COLUMBIA CARE CENTER	1	RICHLAND	COLUMBIA	PROP	178	178	294	53,392
CRAFTS FARROW FORENSIC BUILDING	2	RICHLAND	COLUMBIA	ST	0	0		
G WERBER BRYAN PSYCHIATRIC HOSP	1	RICHLAND	COLUMBIA	ST	492	492	850	82,400
GILLIAM PSYCHIATRIC HOSPITAL		RICHLAND	COLUMBIA	ST	87	87		
SC STATE HOSPITAL	3	RICHLAND	COLUMBIA	ST	144	501		
(WM J MCCORD ADOLESCENT TREAT)	4	ORANGEBURG	ORANGEBURG	ST	(0)	(0)		
WILLIAM S HALL PSYCHIATRIC INSTITUTE		RICHLAND	COLUMBIA	ST	89	89	344	7,154
TOTAL					**1,190**	**1,547**	**2,630**	**194,624**
RESIDENTAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:								
DIRECTIONS - WILLIAM S HALL		RICHLAND	COLUMBIA	ST	37	37	42	7,499
TOTAL					**37**	**37**	**42**	**7,499**
DRUG & ALCOHOL INPT TREATMENT:								
PALMETTO CENTER		FLORENCE	FLORENCE	ST	48	48		
HOMESVIEW ALCOHOLIC CTR		GREENVILLE	GREENVILLE	ST	36	36		
WM J MCCORD ADOLESCENT TREAT	4	ORANGEBURG	ORANGEBURG	ST	15	15	162	5,285
WILLIAM S HALL		RICHLAND	COLUMBIA	ST	19	19	44	5,377
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	163	163	1,797	47,775
TOTAL					**281**	**281**	**2,003**	**58,437**
LONG TERM FACILITIES:								
RICHARD M CAMPBELL VA NURS HOME		ANDERSON	ANDERSON	ST	220	220	115	76,104
PRESTON HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	8	8	16	1,786
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	14	14	51	3,954
BISHOP GADSDEN EPISCOPAL		CHARLESTON	CHARLESTON	NPA	9	9	16	2,854

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
THE FRANKE HEALTH CARE CTR		CHARLESTON	MT PLEASANT	NPA	20	20	70	6,623
VETERANS VICTORY HOUSE		COLLETON	WALTERBORO	ST	220	220	181	68,030
BETHEA BAPTIST HOME		DARLINGTON	DARLINGTON	NPA	52	52	43	16,472
PRESBYTERIAN HOME SUMMERVILLE		DORCHESTER	SUMMERVILLE	NPA	0	0		
PRESBYTERIAN HOME FLORENCE	4	FLORENCE	FLORENCE	NPA	26	26	20	11,561
METHODIST MANOR HEALTHCARE CTR		FLORENCE	FLORENCE	NPA	32	32	15	9,870
LAKES AT LITCHFIELD SKILLED NSG CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	7	7	46	1,753
ROLLING GREEN VILLAGE HC FACILITY		GREENVILLE	GREENVILLE	NPA	34	34	68	11,833
LINVILLE COURTS CASCADES VERDAE	5	GREENVILLE	GREENVILLE	PROP	22	22		
(ARBORETUM WOODLANDS)	6	GREENVILLE	GREENVILLE	PROP	(13)	(13)	15	546
PRESBYTERIAN HOME OF SC CLINTON	7	LAURENS	CLINTON	NPA	48	48	39	17,841
MARTHA FRANK BAPTIST HOME		LAURENS	LAURENS	NPA	7	7	11	2,413
SC EPISCOPAL HOME STILL HOPES		LEXINGTON	W COLUMBIA	NPA	42	42	31	12,498
LAUREL CREST RETIREMENT CENTER		LEXINGTON	W COLUMBIA	NPA	12	12	7	3,790
PRESBYTERIAN HOME OF COLUMBIA		LEXINGTON	W COLUMBIA	NPA	44	0	50	14,427
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	22	22	20	5,551
PRESBYTERIAN HOME OF SC - FOOTHILLS		PICKENS	EASLEY	NPA	18	18	10	6,570
CM TUCKER JR NURS CTR-FEWELL/STONE		RICHLAND	COLUMBIA	ST	252	252	69	77,337
CM TUCKER JR NURS CTR-RODDEY		RICHLAND	COLUMBIA	ST	308	308	36	67,273
WILDEWOOD DOWNS NSG & REHAB	8	RICHLAND	COLUMBIA	PROP	8	8	11	630
WJB DORN VETERANS NURSING		RICHLAND	COLUMBIA	FED	62	150		
SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	11	11	18	3,117
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	6	6	24	1,296
COVENANT PLACE NURS CTR		SUMTER	SUMTER	NPA	44	44	25	1,338
TOTAL					**1,548**	**1,592**	**1,007**	**425,467**

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED:

DR DON LESTER PEOPLES COMM RES		ABBEVILLE	WARE SHOALS	ST	8	8
WARE SHOALS HAB CTR I		ABBEVILLE	WARE SHOALS	ST	8	8
ABBEVILLE COUNTY		TOTAL			16	16
DUPONT I HABILITATION CTR		AIKEN	AIKEN	ST	8	8
DUPONT II HABILITATION CTR		AIKEN	AIKEN	ST	8	8
LAURENS STREET ICF/MR		AIKEN	AIKEN	ST	8	8
LINDEN STREET ICR/MR		AIKEN	AIKEN	ST	8	8
RUDNICK HABILITATION CTR		AIKEN	AIKEN	ST	8	8
SANDERS HABILITATION CTR		AIKEN	AIKEN	ST	8	8
AIKEN COUNTY		TOTAL			48	48
ACADEMY STREET COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8
BLACK'S DRIVE COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8
HARLEY ROAD COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8
LEMON PARK COMMUNITY RES		BARNWELL	BARNWELL	ST	8	8
BARNWELL COUNTY		TOTAL			32	32
CONIFER I COMMUNITY RESIDENCE		BERKELEY	MONCKS CORNER	ST	8	8
CONIFER II COMMUNITY RESIDENCE		BERKELEY	MONCKS CORNER	ST	8	8
BERKELEY COUNTY		TOTAL			16	16

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
FLORENCE GRESSETTE RESIDENCE		CALHOUN	ST MATTHEWS	ST	8	8		
WYLIE-BRUNSON RESIDENCE		CALHOUN	ST MATTHEWS	ST	8	8		
CALHOUN COUNTY		TOTAL			16	16		
DILLS BLUFF COMMUNITY RESIDENCE		CHARLESTON	CHARLESTON	ST	8	8		
CHARLESTON COUNTY		TOTAL			8	8		
J. CLAUDE FORT COMMUNITY RES #1		CHEROKEE	GAFFNEY	ST	8	8		
J. CLAUDE FORT COMMUNITY RES #2		CHEROKEE	GAFFNEY	ST	8	8		
CHEROKEE COUNTY		TOTAL			16	16		
CHARLES M. INGRAM, SR COMM RES		CHESTERFIELD	CHERAW	ST	8	8		
CHESTERFIELD COMMUNITY RES		CHESTERFIELD	CHESTERFIELD	ST	8	8		
CHESTERFIELD COUNTY		TOTAL			16	16		
JOSIE DRIVE COMMUNITY RESIDENCE		COLLETON	WALTERBORO	ST	8	8		
FOREST CIRCLE COMMUNITY RES		COLLETON	WALTERBORO	ST	8	8		
COLLETON COUNTY		TOTAL			16	16		
JOHN A REAGAN COMMUNITY RES		DARLINGTON	HARTSVILLE	ST	8	8		
THAD E SALEEBY DEVELOPMENT CTR		DARLINGTON	HARTSVILLE	ST	96	96		
WILLIAM W BOWEN RESIDENCE		DARLINGTON	HARTSVILLE	ST	8	8		
DARLINGTON COUNTY		TOTAL			112	112		
COASTAL CTR -HIGHLANDS & HILLSIDE		DORCHESTER	SUMMERVILLE	ST	192	192		
COASTAL CENTER- HIGHLANDS 510		DORCHESTER	SUMMERVILLE	ST	18	18		
PARSONS I GROUP HOME		DORCHESTER	SUMMERVILLE	ST	8	8		
PARSONS II GROUP HOME		DORCHESTER	SUMMERVILLE	ST	8	8		
DORCHESTER COUNTY		TOTAL			226	226		
EDGEFIELD COMMUNITY RESIDENCE		EDGEFIELD	EDGEFIELD	ST	8	8		
EDGEFIELD COUNTY		TOTAL			8	8		
THE CEDARS		FLORENCE	PAMPLICO	ST	8	8		
FLORENCE COMMUNITY RESIDENCE		FLORENCE	FLORENCE	ST	8	8		
JOHNSONVILLE HAMPTON PLACE COM		FLORENCE	JOHNSONVILLE	ST	8	8		
MAGNOLIA PLACE		FLORENCE	OLANTA	ST	8	8		
MULBERRY PARK, UNITS 301-306		FLORENCE	FLORENCE	ST	85	85		
THE OAKS		FLORENCE	TIMMONSVILLE	ST	8	8		
PECAN LANE, BUILDINGS 201-205		FLORENCE	FLORENCE	ST	120	120		
FLORENCE COUNTY		TOTAL			245	245		
JESSAMINE COMMUNITY RESIDENCE		GEORGETOWN	GEORGETOWN	ST	8	8		
MARYVILLE COMMUNITY RESIDENCE		GEORGETOWN	GEORGETOWN	ST	8	8		
GEORGETOWN COUNTY					16	16		
CIVITAN COMMUNITY RESIDENCE		GREENVILLE	GREENVILLE	ST	8	8		
FOUNTAIN INN COMMUNITY RESIDENCE		GREENVILLE	FOUNTAIN INN	ST	12	12		
HUGHES STREET COMMUNITY RES		GREENVILLE	FOUNTAIN INN	ST	8	8		
MARIAN PARKINS COMMUNITY RES I		GREENVILLE	GREENVILLE	ST	8	8		
MARIAN PARKINS COMMUNITY RES II		GREENVILLE	GREENVILLE	ST	8	8		
RIDGE ROAD RESIDENCE		GREENVILLE	GREENVILLE	ST	12	12		
TRAVELERS REST COMMUNITY RES		GREENVILLE	TRAVELERS REST	ST	8	8		
GREENVILLE COUNTY		TOTAL			64	64		

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
HENRY & FREIDA BONDS HAB CTR		GREENWOOD	GREENWOOD	ST	8	8		
MARION P CARNELL HAB CTR		GREENWOOD	WARE SHOALS	ST	8	8		
J. FELTON BURTON COMMUNITY RES		GREENWOOD	GREENWOOD	ST	8	8		
GREENWOOD COUNTY		TOTAL			24	24		
HORRY CO LADIES COMMUNITY RES		HORRY	CONWAY	ST	8	8		
THE LOIS EARGLE HOME		HORRY	CONWAY	ST	8	8		
HORRY COUNTY		TOTAL			16	16		
CAMDEN I GROUP HOME		KERSHAW	CAMDEN	ST	8	8		
CAMDEN II GROUP HOME		KERSHAW	CAMDEN	ST	8	8		
KERSHAW COUNTY		TOTAL			16	16		
NANCY J MCCONNELL COMMUNITY RES		LANCASTER	LANCASTER	ST	8	8		
TOM MANGUM COMMUNITY RESIDENCE		LANCASTER	LANCASTER	ST	8	8		
LANCASTER COUNTY		TOTAL			16	16		
CLINTON MANOR COMMUNITY RES		LAURENS	CLINTON	ST	8	8		
DAVIDSON STREET COMMUNITY RES		LAURENS	CLINTON	ST	8	8		
MILL STREET COMMUNITY RESIDENCE		LAURENS	CLINTON	ST	8	8		
SOUTH HARPER ST HABILITATION CTR		LAURENS	CLINTON	ST	8	8		
SULLIVAN STREET COMMUNITY RES		LAURENS	LAURENS	ST	8	8		
OAK GROVE COMMUNITY RESIDENCE		LAURENS	LAURENS	ST	8	8		
WHITTEN CTR CTL SQ 201,204,205,207,209		LAURENS	CLINTON	ST	143	143		
WHITTEN CENTER CAMPUS AREA 101-110		LAURENS	CLINTON	ST	152	152		
WHITTEN CENTER SUBER UNITS 301-303		LAURENS	CLINTON	ST	68	68		
LAURENS COUNTY		TOTAL			411	411		
MCLEOD I GROUP HOME		LEE	BISHOPVILLE	ST	8	8		
MCLEOD II GROUP HOME		LEE	BISHOPVILLE	ST	8	8		
LEE COUNTY		TOTAL			16	16		
BRUTON SMITH ROAD GROUP HOME		LEXINGTON	LEXINGTON	ST	8	8		
BATESBURG GROUP HOME		LEXINGTON	BATESBURG	ST	8	8		
HENDRIX STREET GROUP HOME		LEXINGTON	LEXINGTON	ST	8	8		
NAZARETH ROAD COMMUNITY RES		LEXINGTON	LEXINGTON	ST	8	8		
WIRE ROAD COMMUNITY RESIDENCE I		LEXINGTON	GILBERT	ST	8	8		
WIRE ROAD COMMUNITY RESIDENCE II		LEXINGTON	GILBERT	ST	8	8		
LEXINGTON COUNTY		TOTAL			48	48		
JENNINGS MCABEE HABILITATION CTR		MCCORMICK	MCCORMICK	ST	8	8		
MCCORMICK COUNTY		TOTAL			8	8		
H.A. MCCULLOUGH COMMUNITY RES		NEWBERRY	NEWBERRY	ST	12	12		
NEWBERRY COUNTY		TOTAL			12	12		
OCONEE COMMUNITY RESIDENCE I		OCONEE	SENECA	ST	8	8		
OCONEE COUNTY		TOTAL			8	8		

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
NANCE COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8		
KINGS COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8		
SIFLY COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8		
WANNAMAKER ST COMMUNITY RES		ORANGEBURG	ORANGEBURG	ST	8	8		
ORANGEBURG COUNTY		TOTAL			32	32		
ARCHIE DRIVE GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
CARTER STREET GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
FIRST MIDLANDS ICF-MR		RICHLAND	COLUMBIA	ST	344	344		
HORRELL HILL COMMUNITY RESIDENCE		RICHLAND	HOPKINS	ST	8	8		
IDA I COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8		
IDA II COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8		
KENSINGTON I GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
KENSINGTON II GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
NORTH PINES COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8		
RABBIT RUN COMMUNITY RESIDENCE		RICHLAND	HOPKINS	ST	8	8		
WOODLAWN GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
RICHLAND COUNTY		TOTAL			424	424		
BENCHMARK HOMES-SPARTANBURG		SPARTANBURG	SPARTANBURG	ST	12	12		
BENCHMARK HOMES-COWPENS		SPARTANBURG	COWPENS	ST	12	12		
LANDRUM COMMUNITY RESIDENCE I		SPARTANBURG	LANDRUM	ST	8	8		
LANDRUM COMMUNITY RESIDENCE II		SPARTANBURG	LANDRUM	ST	8	8		
SPARTANBURG COUNTY		TOTAL			40	40		
ATKINSON EAST COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	9	9		
ATKINSON WEST COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	9	9		
THOMAS DRIVE COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	8	8		
SUMTER COUNTY		TOTAL			26	26		
WEST MAIN STREET COMMUNITY RES		UNION	UNION	ST	8	8		
UNION COUNTY		TOTAL			8	8		
TOTAL					**1,960**	**1,960**		

FOOTNOTES 2010-2011 PLAN

STATEWIDE

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. E-08-78 granted 8/8/08 to return the 178 psychiatric beds on loan to Just Care to G. Werber Bryan for a total of 466 psychiatric beds at GWB. License decreased by 24 beds to 442 beds 5/28/09. Added 50 psych beds 10/1/09 when Crafts Farrow Forensic Building closed, for a total of 492 beds.
2. Initially licensed for 50 psychiatric/forensic care beds 11/5/08. De-licensed 10/1/09 and the 50 beds transferred to G. Werber Bryan.
3. CON issued 7/16/10 to convert the McCord Adolescent Treatment Facility to a specialized hospital restricted primarily to the provision of alcohol and drug abuse treatment for adolescents.
4. Exemption issued 4/16/10 for the permanent de-licensure of 18 beds, for a total of 26 licensed nursing home beds. Licensed for 26 beds 6/24/10.
5. CON issued 9/14/07 for a Continuing Care Retirement Community with 44 institutional nursing home beds, SC-07-41. Licensed for 22 beds 4/21/09; licensed for 44 beds 4/23/09. CON issued 5/12/09 to convert 22 of the beds from institutional beds to nursing home beds not participating in the Medicaid program. The licensed was amended 5/12/09 to reflect the change to 22 institutional and 22 nursing home beds not participating in the Medicaid program.
6. CON approved 6/13/06 to construct a Continuing Care Retirement Community with 13 institutional nursing home beds and 17 nursing home beds that do not participate in the Medicaid program. Licensed 6/2/09. CON issued 6/10/10 to convert the 13 institutional beds to community beds, SC-10-17. Licensed for 30 community beds effective 6/10/10.
7. CON issued 3/12/09 to change the licensure of 18 institutional beds to community beds not participating in the Medicaid program, SC-09-14. Licensed amended 4/23/09.
8. CON issued 9/11/08 for the addition of 8 institutional beds and 40 general nursing home beds for a total of 80 beds (8 institutional and 72 general), SC-08-35. Licensed 9/10/09.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: I FISCAL YEAR: 2009

1. Unusual Characteristics: There are no unusual characteristics such as military bases with associated dependents, nor barriers to transportation in this region.

2. General Hospitals: W.J. Barge Hospital is a privately owned Educational Institutional Infirmary.

3. Nursing Homes: There is a need for additional nursing home beds in this area.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	423	423	14,166	75,895	423	49.2%
ANMED HEALTH WOMEN'S & CHILDREN'S HOSPITAL		ANDERSON	ANDERSON	NPA	72	72	3,259	8,015	72	30.5%
ANDERSON COUNTY		TOTAL			495	495	17,425	83,910	495	46.4%
UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125	4,098	17,417	125	38.2%
CHEROKEE COUNTY		TOTAL			125	125	4,098	17,417	125	38.2%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	746	746	32,908	170,549	746	62.6%
GREER MEMORIAL HOSPITAL		GREENVILLE	GREER	NPA	82	82	3,565	13,851	68.9	55.1%
HILLCREST MEMORIAL HOSPITAL		GREENVILLE	SIMPSONVILLE	NPA	43	43	1,756	6,553	43	41.8%
PATEWOOD MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	72	72	1,295	2,925	72	11.1%
SAINT FRANCIS - DOWNTOWN	1	GREENVILLE	GREENVILLE	NPA	226	224	12,045	58,914	226	71.4%
SAINT FRANCIS MILLENNIUM	1	GREENVILLE	GREENVILLE	NPA		52				
SAINT FRANCIS - EASTSIDE		GREENVILLE	GREENVILLE	NPA	93	93	6,167	18,039	93	53.1%
GREENVILLE COUNTY		TOTAL			1,262	1,312	57,736	270,831	1,249	59.4%
OCONEE MEDICAL CENTER	2	OCONEE	SENECA	NPA	169	169	6,991	28,012	160	48.0%
OCONEE COUNTY					169	169	6,991	28,012	160	48.0%
BAPTIST EASLEY HOSPITAL	3	PICKENS	EASLEY	NPA	109	109	4,729	18,616	109	46.8%
CANNON MEMORIAL HOSPITAL		PICKENS	PICKENS	NPA	42	42	960	3,635	55	18.1%
PICKENS COUNTY		TOTAL			42	42	960	3,635	55	18.1%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	176	176	6,689	26,934	176	41.9%
SPARTANBURG REGIONAL MEDICAL CENTER	4	SPARTANBURG	SPARTANBURG	CO	484	484	26,503	136,771	522.2	71.8%
VILLAGE HOSPITAL	4	SPARTANBURG	GREER	CO	48	48	961	3,152	48	18.0%
SPARTANBURG COUNTY		TOTAL			708	708	34,153	166,857	746.2	61.3%
WALLACE THOMSON HOSPITAL		UNION	UNION	DIST	143	143	2,356	9,466	143	18.1%
UNION COUNTY		TOTAL			143	143	2,356	9,466	143	18.1%
TOTAL					2,944	2,994	123,719	580,128	2,973	53.5%
LONG TERM ACUTE HOSPITALS:										
NORTH GREENVILLE HOSP LONG TERM ACUTE		GREENVILLE	TRAVELERS RES	NPA	45	45	348	10,238	45	62.3%
REGENCY HOSPITAL OF GREENVILLE		GREENVILLE	GREENVILLE	NPA	32	32	329	8,360	32	71.6%
SPARTANBURG HOSPITAL FOR RESTORATIVE CARE		SPARTANBURG	SPARTANBURG	CO	97	97	437	12,243	97	34.6%
TOTAL					129	129	1,114	30,841	174	48.6%
MENTAL FACILITIES:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38	1,076	5,963	38	43.0%
ANDERSON COUNTY		TOTAL			38	38	1,076	5,963	38	43.0%
CAROLINA CENTER FOR BEHAVIORAL HEALTH	5	GREENVILLE	GREENVILLE	PROP	99	99	2,263	24,795	76	89.4%
SPRINGBROOK BEHAVIORAL HEALTHCARE	6	GREENVILLE	TRAVELERS RES	PROP	20	37	398	4,682	20	64.1%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	46	46	1,376	14,280	46	85.1%
GREENVILLE COUNTY		TOTAL			165	182	4,037	43,757	142	84.4%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15	352	4,014	15	73.3%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	56	56	575	4,987	56	24.4%
SPARTANBURG COUNTY		TOTAL			71	71	927	9,001	71	34.7%
TOTAL					274	291	6,040	58,721	251	64.1%

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
EXCALIBUR YOUTH SERVICES	7	GREENVILLE	SIMPSONVILLE	PROP	60	60	47	8,972	51.3	47.9%
GENERATIONS ALTERNATIVE - BRIDGES	8	GREENVILLE	GREENVILLE	PROP		10				
GENERATIONS ALTERNATIVE - HORIZONS	8	GREENVILLE	GREENVILLE	PROP		20				
MARSHALL I. PICKENS CHILDREN'S PROGRAM		GREENVILLE	GREENVILLE	NPA	22	22	28	7,145	22	89.0%
SPRINGBROOK BEHAVIORAL HEALTHCARE		GREENVILLE	TRAVELERS RES	PROP	68	68	85	19,904	68	80.2%
AVALONIA GROUP HOME	9	PICKENS	PICKENS	PROP	55	55	37	11,210	55	55.8%
TOTAL					205	235	197	47,231	196	65.9%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
CAROLINA CENTER FOR BEHAVIORAL HEALTH		GREENVILLE	GREENVILLE	PROP	13	13	614	4,896	13	103.2%
TOTAL					13	13	614	4,896	13	103.2%
REHABILITATION FACILITIES:										
ANMED HEALTH REHABILITATION HOSPITAL	10	ANDERSON	ANDERSON	PROP	45	45	943	13,010	38.5	92.6%
ANDERSON COUNTY		TOTAL			45	45	943	13,010	38.5	92.6%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	53	53	701	11,413	53	59.0%
SAINT FRANCIS HOSPITAL - DOWNTOWN		GREENVILLE	GREENVILLE	NPA	19	19	482	6,210	19	89.5%
GREENVILLE COUNTY		TOTAL			72	72	1,183	17,623	72	67.1%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	18	18	334	4,260	18	64.8%
SPARTANBURG COUNTY		TOTAL			18	18	334	4,260	18	64.8%
TOTAL					135	135	2,460	34,893	129	74.4%
INPATIENT HOSPICE FACILITIES:										
CALLIE & JOHN RAINEY / HOSPICE OF THE UPSTATE		ANDERSON	ANDERSON	NPA	32	32	659	8,456	32	72.4%
MCCALL HOSPICE HOUSE OF GREENVILLE		GREENVILLE	SIMPSONVILLE	NPA	30	30	438	8,339	30	76.2%
OCONEE MEMORIAL HOSPICE FOOTHILLS		OCONEE	SENECA	NPA	15	15	247	3,270	15	59.7%
HOSPICE HOUSE OF CAROLINA FOOTHILLS	11	SPARTANBURG	LANDRUM	NPA	12	12	97	1,242	12	28.4%
SPARTANBURG REG HEALTHCARE HOSPICE		SPARTANBURG	SPARTANBURG	NPA	15	15	613	4,847	15	88.5%
TOTAL					104	104	2,054	26,154	104	68.9%
LONG TERM CARE FACILITIES:										
ANDERSON PLACE		ANDERSON	ANDERSON	PROP	44	44	31	10,244	44	63.8%
EXALTED HEALTH & REHAB IVA	12	ANDERSON	IVA	PROP	60	60	136	21,196	60	96.8%
ELLENBURG NURSING CENTER		ANDERSON	ANDERSON	PROP	181	181	232	63,503	181	96.1%
FELLOWSHIP HEALTH & REHAB ANDERSON	13	ANDERSON	ANDERSON	PROP	88	88	264	30,896	88	96.2%
GARDENS AT TOWN CREEK	14	ANDERSON	PENDLETON	PROP	0	60				
HOSANNA HEALTH & REHAB PIEDMONT	15	ANDERSON	ANDERSON	PROP	88	88	297	31,190	88	97.1%
NHC HEALTHCARE ANDERSON		ANDERSON	ANDERSON	PROP	290	290	549	103,499	290	97.8%
ANDERSON COUNTY		TOTAL			751	811	1,509	260,528	751	95.0%
BROOKVIEW HEALTHCARE CENTER		CHEROKEE	GAFFNEY	PROP	132	132	142	45,828	132	94.9%
CHEROKEE COUNTY LONG TERM CARE FACILITY	16	CHEROKEE	GAFFNEY	CO	111	111	195	34,779	102.8	92.4%
CHEROKEE COUNTY		TOTAL			243	243	337	80,607	234.8	93.8%
ALPHA HEALTH & REHAB GREER	17	GREENVILLE	GREER	PROP	132	132	456	44,639	132	92.7%
ARBORETUM OF WOODLANDS AT FURMAN	18	GREENVILLE	GREENVILLE	PROP	30	30	19	717	9.9	19.8%
(ARBORETUM OF WOODLANDS AT FURMAN)		GREENVILLE	GREENVILLE	PROP	(0)	(0)				
BRIGHTON GARDENS		GREENVILLE	GREENVILLE	PROP	45	45	152	14,155	45	86.2%
COTTAGES AT BRUSHY CREEK		GREENVILLE	GREENVILLE	NPA	144	144	411	43,380	144	82.5%
DAYSPRING HEALTH & REHAB SIMPSONVILLE	19	GREENVILLE	SIMPSONVILLE	PROP	42	42	20	13,918	42	90.8%
DIAMOND HEALTH & REHAB SIMPSONVILLE	20	GREENVILLE	SIMPSONVILLE	PROP	132	132	330	45,108	132	93.6%
GLORIFIED HEALTH & REHAB GREENVILLE	21	GREENVILLE	GREENVILLE	PROP	132	132	314	45,791	132	95.0%
GREENVILLE LIVING CENTER		GREENVILLE	GREENVILLE	PROP	79	79	78	26,770	79	92.8%
GREENVILLE MEMORIAL MED CTR SUBACUTE		GREENVILLE	GREENVILLE	NPA	15	15	316	4,443	15	81.2%
HOPE HEALTH & REHAB MARIETTA	22	GREENVILLE	MARIETTA	NPA	44	44	42	15,590	44	97.1%
LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	GREENVILLE	PROP	132	132	210	43,814	132	90.9%

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
LINVILLE COURTS AT CASCADES VERDAE	23	GREENVILLE	GREENVILLE	PROP	22	22				
(LINVILLE COURTS AT CASCADES VERDE)		GREENVILLE	GREENVILLE	PROP	(22)	(22)				
MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	99	99	49	34,142	99	94.5%
MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120	92	41,650	120	95.1%
NHC HEALTHCARE GREENVILLE		GREENVILLE	GREER	PROP	176	176	483	62,329	176	97.0%
NHC HEALTHCARE MAULDIN		GREENVILLE	MAULDIN	PROP	180	180	455	63,211	180	96.2%
OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132	357	44,440	132	92.2%
OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125	322	42,439	124	93.8%
OMEGA HEALTH & REHAB GREENVILLE	24	GREENVILLE	FOUNTAIN INN	PROP	60	60	109	18,681	56.4	90.7%
ROLLING GREEN VILLAGE HEALTH CARE FACILITY		GREENVILLE	GREENVILLE	NPA	10	10	20	3,481	10	95.4%
(ROLLING GREEN VILLAGE HEALTH CARE FACILITY)		GREENVILLE	GREENVILLE	NPA	(34)	(34)				
GREENVILLE COUNTY		TOTAL			1,851	1,851	4,235	608,698	1,804.3	92.2%
LILA DOYLE NURSING CARE FACILITY		OCONEE	SENECA	CO	120	120	539	41,143	120	93.9%
SENECA HEALTH AND REHABILITATION CENTER		OCONEE	SENECA	PROP	132	132				
OCONEE COUNTY		TOTAL			252	252	539	41,143	120	93.9%
CAPSTONE HEALTH & REHAB EASLEY	25	PICKENS	EASLEY	PROP	66	66	92	20,287	66	84.2%
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	30	30	26	7,571	30	69.1%
(CLEMSON AREA RETIREMENT CENTER)		PICKENS	CLEMSON	PROP	(22)	(22)				
COUNTRYSIDE HEALTHCARE CENTER		PICKENS	EASLEY	PROP	44	44	27	9,234	44	57.5%
MAJESTY HEALTH & REHAB EASLEY	26	PICKENS	EASLEY	PROP	103	103	247	33,136	103	88.1%
HERITAGE HEALTHCARE OF PICKENS		PICKENS	SIX MILE	PROP	44	44	34	15,588	44	97.1%
MANNA HEALTH & REHAB PICKENS	27	PICKENS	PICKENS	PROP	80	80	190	28,307	80	96.9%
PRESBYTERIAN HOME - FOOTHILLS	28	PICKENS	EASLEY	PROP	26	26				
(PRESBYTERIAN HOME - FOOTHILLS)		PICKENS	EASLEY	PROP	(18)	(18)				
REDEEMER HEALTH & REHAB PICKENS	29	PICKENS	PICKENS	PROP	44	44	49	15,488	44	96.4%
PICKENS COUNTY		TOTAL			437	437	665	129,611	411	86.4%
CAMP CARE		SPARTANBURG	INMAN	PROP	88	88	85	31,399	88	97.8%
GOLDEN AGE - INMAN		SPARTANBURG	INMAN	PROP	44	44	27	15,187	44	94.6%
INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	40	20	13,618	40	93.3%
MAGNOLIA MANOR - INMAN		SPARTANBURG	INMAN	PROP	176	176	186	62,803	176	97.8%
MAGNOLIA MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	95	95	82	28,753	95	82.9%
MAGNOLIA PLACE - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	88	88	127	30,602	88	95.3%
MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132	44	47,590	132	98.8%
ROSECREST REHABILITATION & HEALTHCARE		SPARTANBURG	INMAN	NPA	75	75	230	23,939	75	87.4%
SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	33	33	56	9,353	33	77.7%
(SKYLYN HEALTH CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)	14			
SPARTANBURG HOSP RESTORATIVE CARE SNF		SPARTANBURG	SPARTANBURG	CO	25	25	392	4,984	25	54.6%
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	27	27	111	5,833	27	59.2%
(SUMMIT HILLS NURSING CENTER)		SPARTANBURG	SPARTANBURG	PROP	(6)	(6)				
VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88	48	30,801	88	95.9%
WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192	166	67,207	192	95.9%
WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88	101	31,703	88	98.7%
WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88	15	32,120	88	100.0%
SPARTANBURG COUNTY		TOTAL			1,279	1,279	1,704	435,892	1,279	93.4%
ELLEN SAGAR NURSING HOME		UNION	UNION	CO	113	113			113	
OAKMONT OF UNION		UNION	UNION	PROP	88	88			88	
UNION COUNTY		TOTAL			201	201	0	0	201	0.0%
TOTAL					5,014	5,074	8,989	1,556,479	4,801	88.8%

FOOTNOTES 2010-2011 PLAN

REGION I

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 6/12/09 to construct a new 52 bed hospital (St. Francis millennium) through the transfer of the 50 bed need generated by St. Francis Downtown and the transfer of 2 beds from St. Francis Downtown, for a total of 224 beds at St. Francis Downtown, SC-09-28.
2. CON issued for a 9 bed addition 9/14/06, SC-06-55. Licensed for 169 beds, 4/15/10. Name changed from Oconee Memorial Hospital.
3. Formerly Palmetto Baptist Medical Center Easley.
4. CON issued 9/9/05 to construct Village Health Centre, a new 48-bed hospital, by transferring 48 acute care beds from Spartanburg Regional Medical Center, SC-05-63. Village Hospital licensed for 48 beds and the number of licensed beds at SRMC was reduced from 532 to 484 on 9/23/08.
5. CON issued 8/10/09 to add 23 psych beds for a total of 99 psych and 13 substance abuse beds, SC-09-37. Licensed 8 additional psych beds for a total of 84, 2/16/10. Licensed for 99 beds 9/23/10.
6. CON issued 8/10/09 to add 17 psych beds for a total of 37 psych and 68 RTF beds, SC-09-38.
7. Facility converted from a High Management Group Home, licensed for 42 Residential Treatment Facility 12/31/08. CON issued 3/26/09 to add 18 beds for a total of 60, SC-09-15. Licensed for 60 beds 6/26/09.
8. Exemption to convert from a High Maintenance Group Home to an RTF.
9. Facility converted from a High Maintenance Group Home to a 55 bed Residential Treatment Facility on 9/18/08.
10. CON to convert 3 nursing home beds to rehab beds, for a total of 40 rehab beds 5/14/09, SC-09-25. CON issued for 5 additional rehab beds, for a total of 45, 7/8/09, SC-09-35. Licensed for 40 rehab beds 7/1/09; licensed for 45 beds 4/22/10.
11. CON issued 7/28/06 for a 12-bed inpatient hospice facility, SC-06-44. Licensed 3/31/09.
12. Formerly Willow Creek Living Center.
13. Formerly Brookside Living Center.
14. CON issued 9/9/10 to construct a 60 bed nursing home that does not participate in the Medicaid program, SC-10-29.
15. Formerly Riverside Living Center.
16. CON issued 11/12/08 to add 14 additional nursing home beds for a total of 111 beds, SC-08-49. Licensed for 111 beds 5/5/09.
17. Formerly Piedmont Living Center.
18. CON issued 7/3/06 to construct a Continuing Care Retirement Community with 13 institutional nursing home beds and 17 nursing home beds which do not participate in Medicaid, SC-06-34. Licensed 6/2/09. CON issued 6/10/10 to convert the 13 institutional beds to community beds, SC-10-17. Licensed for 30 community beds, 6/10/10.
19. Formerly Briarwood Living Center.
20. Formerly Summit Place Living Center.

21. Formerly Westside Living Center.
22. Formerly Falls Creek Living Center.
23. CON issued 9/14/07 for a Continuing Care Retirement Community with 44 institutional nursing home beds, SC-07-41, called the Skilled Nursing Center at Cascades Verde. Licensed for 22 beds 4/21/09; licensed for 44 beds 4/23/09. CON issued 5/12/09 to convert 22 of the beds from institutional beds to nursing home beds not participating in the Medicaid program. The licensed was amended 5/12/09 to reflect the change to 22 institutional and 22 nursing home beds not participating in the Medicaid program. Name changed 8/8/09.
24. CON issued 7/29/05 to construct a replacement facility and add 16 beds that do not participate in the Medicaid Program, for a total of 60 nursing home beds, SC-05-53. CON voided and then replaced with CON SC-08-04, 1/24/08. Licensed for 60 beds 3/24/09. Formerly Greenville Living Center.
25. Formerly Blue Ridge Living Center.
26. Formerly Easley Living Center.
27. Formerly Laurel Hill Nursing Center.
28. CON issued 1/14/10 to construct 26 nursing home beds for a total of 44, with 18 restricted to residents of the retirement community, SC-10-04.
29. Formerly Rosemond Living Center.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS
REGION I:	EMERGENCY FACILITIES	
II	ANMED HEALTH MEDICAL CENTER	85,695
III	UPSTATE CAROLINA MEDICAL CENTER	31,778
II	GREENVILLE MEMORIAL HOSPITAL	87,710
I	GREER MEMORIAL/ALLEN BENNETT	31,143
II	HILLCREST HOSPITAL	28,706
III	NORTH GREENVILLE LTACH	18,950
II	SAINT FRANCIS - DOWNTOWN	41,026
II	SAINT FRANCIS - EASTSIDE	32,200
III	OCONEE MEMORIAL HOSPITAL	39,162
III	PALMETTO BAPTIST MED CTR-EASLEY	42,289
III	CANNON MEMORIAL HOSPITAL	18,007
III	MARY BLACK MEMORIAL HOSPITAL	27,838
I	SPARTANBURG REGIONAL MED CTR	106,505
III	WALLACE THOMSON HOSPITAL	18,955
		609,964

REGION I:	TRAUMA CENTERS	
II	ANMED HEALTH MEDICAL CENTER	
I	GREENVILLE MEMORIAL HOSPITAL	
III	GREER MEMORIAL	
I	SPARTANBURG REGIONAL MED CTR	

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: II FISCAL YEAR: 2009

1. Unusual Characteristics: This region has a military base at Fort Jackson with a military hospital to provide health care services for the active duty and dependents residing in this region. A 457 bed Veterans Administration Hospital and 120 bed Veterans Nursing Home is located in Columbia. There are no barriers to transportation. Most State owned psychiatric facilities and the largest substance abuse treatment facility are located in this region.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. After a review of patient origin information, the population used to calculate Richland County hospital bed need is 91.4% of the Richland County population plus 40.9% of the population of Lexington County. For Lexington County, 59.1% of the Lexington County population plus 8.6% of the Richland County population is used. A separate bed need is indicated for each county.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ABBEVILLE AREA MEDICAL CENTER		ABBEVILLE	ABBEVILLE	CO	25	25	803	2,557	25	28.0%
ABBEVILLE COUNTY		TOTAL			25	25	803	2,557	25	28.0%
CHESTER REGIONAL MEDICAL CENTER		CHESTER	CHESTER	DIST	82	82	2,035	6,983	82	23.3%
CHESTER COUNTY		TOTAL			82	82	2,035	6,983	82	23.3%
EDGEFIELD COUNTY HOSPITAL		EDGEFIELD	EDGEFIELD	CO	25	25	494	1,748	25	19.2%
EDGEFIELD COUNTY		TOTAL			25	25	494	1,748	25	19.2%
FAIRFIELD MEMORIAL HOSPITAL		FAIRFIELD	WINNSBORO	NPA	25	25	575	2,916	25	32.0%
FAIRFIELD COUNTY		TOTAL			25	25	575	2,916	25	32.0%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	354	354	13,026	53,099	340.1	42.8%
GREENWOOD COUNTY		TOTAL			354	354	13,026	53,099	340.1	42.8%
KERSHAW HEALTH		KERSHAW	CAMDEN	CO	121	121	5,807	26,724	121	60.5%
KERSHAW COUNTY		TOTAL			121	121	5,807	26,724	121	60.5%
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	168	217	7,276	32,159	168	52.4%
LANCASTER COUNTY		TOTAL			168	217	7,276	32,159	168	52.4%
LAURENS COUNTY HOSPITAL		LAURENS	LAURENS	DIST	76	76	2,972	11,977	76	43.2%
LAURENS COUNTY		TOTAL			76	76	2,972	11,977	76	43.2%
LEXINGTON MEDICAL CENTER	2	LEXINGTON	WEST COLUMBIA	CO	414	414	19,346	89,987	361.4	68.2%
LEXINGTON COUNTY		TOTAL			414	414	19,346	89,987	361.4	68.2%
NEWBERRY COUNTY MEMORIAL HOSPITAL		NEWBERRY	NEWBERRY	CO	90	90	2,462	10,015	90	30.5%
NEWBERRY COUNTY		TOTAL			90	90	2,462	10,015	90	30.5%
PALMETTO HEALTH BAPTIST	3	RICHLAND	COLUMBIA	NPA	363	287	15,351	70,704	363	53.4%
PALMETTO HEALTH PARKRIDGE	3	RICHLAND	COLUMBIA	NPA		76				
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	NPA	579	579	36,344	165,062	579	78.1%
PROVIDENCE HOSPITAL		RICHLAND	COLUMBIA	PROP	258	258	10,328	52,154	258	55.4%
PROVIDENCE HOSPITAL NORTHEAST	4	RICHLAND	COLUMBIA	PROP	56	84	3,151	10,295	46	61.3%
(MONCRIEF ARMY HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(63)				
(W J B DORN VA HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(400)				
RICHLAND COUNTY		TOTAL			1,256	1,284	65,174	298,215	1,246	65.6%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	268	268	12,769	55,838	268	57.1%
YORK COUNTY		TOTAL			268	268	12,769	55,838	268	57.1%
TOTAL					2,904	2,981	132,739	592,218	2,828	57.4%
LONG TERM ACUTE HOSPITALS:										
INTERMEDICAL HOSPITAL OF SOUTH CAROLINA		RICHLAND	COLUMBIA	NPA	35	35	269	8,676	35	67.9%
TOTAL					35	35	269	8,676	35	67.9%
MENTAL FACILITIES:										
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	36	36	656	4,487	36	34.1%
GREENWOOD COUNTY		TOTAL			36	36	656	4,487	36	34.1%
THREE RIVERS BEHAVIORAL HEALTH	6	LEXINGTON	WEST COLUMBIA	PROP	81	81	1,361	16,266	64.3	69.3%
LEXINGTON COUNTY		TOTAL			81	81	1,361	16,266	64.3	69.3%
PALMETTO HEALTH BAPTIST	7	RICHLAND	COLUMBIA	NPA	94	94	1,886	22,507	94	65.6%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	60	60	821	6,616	60	30.2%
(MONCRIEF ARMY HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(20)				

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
(W J B DORN VA)	5	RICHLAND	COLUMBIA	FED		(60)				
RICHLAND COUNTY		TOTAL			154	154	2,707	29,123	154	51.8%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20	565	3,424	20	46.9%
YORK COUNTY		TOTAL			20	20	565	3,424	20	46.9%
TOTAL					291	291	5,289	53,300	274	53.1%
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
THREE RIVERS RESIDENTIAL TREATMENT - MIDLANDS		LEXINGTON	WEST COLUMBIA	PROP	59	59	69	20,251	59	94.0%
THREE RIVERS BEHAVIORAL HEALTH RTC		LEXINGTON	WEST COLUMBIA	PROP	20	20	22	6,496	20	89.0%
CAROLINA CHILDREN'S HOME	8	RICHLAND	COLUMBIA	NPA	20	30	18	1,873	10.9	47.3%
NEW HOPE CAROLINAS	9	YORK	ROCK HILL	PROP	150	150	137	45,916	150	83.9%
YORK PLACE EPISCOPAL HOME		YORK	YORK	PROP	40	40	43	10,555	40	72.3%
TOTAL					289	299	289	85,091	280	83.3%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	18	0	0	0	18	0.0%
THREE RIVERS BEHAVIORAL HEALTH	6	LEXINGTON	WEST COLUMBIA	PROP	17	17	612	3,500	22.7	42.2%
PALMETTO HEALTH BAPTIST	7	RICHLAND	COLUMBIA	CO	10	10	0	0	1.0	0.0%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10	325	3,374	10	92.4%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	24	24	0	0	24	0.0%
TOTAL					79	61	937	6,874	75.7	24.8%
REHABILITATION FACILITIES:										
GREENWOOD REGIONAL REHAB HOSPITAL		GREENWOOD	GREENWOOD	NPA	34	34	783	10,149	34	81.8%
GREENWOOD COUNTY		TOTAL			34	34	783	10,149	34	81.8%
HEALTHSOUTH REHAB HOSPITAL COLUMBIA		RICHLAND	COLUMBIA	PROP	96	96	1,568	21,721	96	62.0%
RICHLAND COUNTY		TOTAL			96	96	1,568	21,721	96	62.0%
HEALTHSOUTH REHAB HOSPITAL ROCK HILL	10	YORK	ROCK HILL	PROP	46	46	928	12,636	40	86.5%
YORK COUNTY		TOTAL			46	46	928	12,636	40	86.5%
TOTAL					176	176	3,279	44,506	170	71.7%
INPATIENT HOSPICE FACILITIES:										
HOSPICE HOUSE OF HOSPICECARE PIEDMONT		GREENWOOD	GREENWOOD	NPA	15	15	440	2,842	15	51.9%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE	11	LAURENS	CLINTON	PROP	12	12	114	1,314	12	30.0%
(HEARTLAND HOSPICE HOUSE MIDLANDS)	12	RICHLAND	COLUMBIA	PROP	(0)	(0)	125	1,616	12	36.9%
ASCENSION HOUSE		RICHLAND	IRMO	PROP	14	14	312	2,573	14	50.4%
HOSPICE AND COMMUNITY CARE		YORK	ROCK HILL	NPA	16	16	250	3,020	16	51.7%
TOTAL					57	57	1,241	11,365	69	45.1%
LONG TERM CARE FACILITIES:										
ABBEVILLE NURSING HOME		ABBEVILLE	ABBEVILLE	PROP	94	94	31	30,762	94	89.7%
CARLISLE NURSING CENTER		ABBEVILLE	DUE WEST	NPA	22	22	13	5,677	22	70.7%
ABBEVILLE COUNTY		TOTAL			116	116	44	36,439	116	86.1%
CHESTER NURSING CENTER		CHESTER	CHESTER	CO	100	100	188	32,231	100	88.3%
CHESTER COUNTY		TOTAL			100	100	188	32,231	100	88.3%
TRINITY MISSION EDGEFIELD		EDGEFIELD	EDGEFIELD	PROP	120	120	76	41,998	120	95.9%
EDGEFIELD COUNTY		TOTAL			120	120	76	41,998	120	95.9%
FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	112	75	39,418	112	96.4%
HERITAGE HEALTHCARE OF RIDGEWAY/UPAC-TANGLEWOOD		FAIRFIELD	RIDGEWAY	PROP	150	150	187	51,646	150	94.3%
FAIRFIELD COUNTY		TOTAL			262	262	262	91,064	262	95.2%

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
GREENWOOD REGIONAL REHAB HOSPITAL		GREENWOOD	GREENWOOD	NPA	12	12	315	3,104	12	70.9%
HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102				
MAGNOLIA MANOR - GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88	53	31,621	88	98.4%
NHC HEALTHCARE - GREENWOOD		GREENWOOD	GREENWOOD	PROP	152	152	166	51,885	152	93.5%
(TRANSITIONAL CARE SELF REGIONAL)		GREENWOOD	GREENWOOD	NPA	0	0				
GREENWOOD COUNTY		TOTAL			354	354	534	86,610	252	94.2%
A SAM KARESH LONG TERM CARE CENTER	13	KERSHAW	CAMDEN	CO	96	96	259	32,740	96	93.4%
SPRINGDALE HEALTHCARE CENTER	14	KERSHAW	CAMDEN	PROP	148	148	385	51,700	148	95.7%
KERSHAW COUNTY		TOTAL			244	244	644	84,440	244	94.8%
LANCASTER CONVALESCENT CENTER		LANCASTER	LANCASTER	NPA	142	142	93	50,312	142	97.1%
TRANSITIONAL CARE UNIT - SPRINGS MEMORIAL		LANCASTER	LANCASTER	NPA	14	14	368	4,253	14	83.2%
WHITE OAK MANOR - LANCASTER		LANCASTER	LANCASTER	NPA	132	132	99	46,875	132	97.3%
LANCASTER COUNTY		TOTAL			288	288	560	101,440	288	96.5%
LAURENS COUNTY HEALTHCARE SYSTEM SNF		LAURENS	LAURENS	DIST	14	14	195	2,646	14	51.8%
MARTHA FRANK BAPTIST RETIREMENT CENTER		LAURENS	LAURENS	NPA	81	81	131	27,940	81	94.5%
(MARTHA FRANK BAPTIST RETIREMENT CENTER)		LAURENS	LAURENS	NPA	(7)	(7)				
NHC HEALTHCARE - CLINTON		LAURENS	CLINTON	PROP	131	131	152	45,353	131	94.9%
NHC HEALTHCARE - LAURENS		LAURENS	LAURENS	PROP	176	176	202	60,323	176	93.9%
PRESBYTERIAN HOME OF SC CLINTON	15	LAURENS	CLINTON	NPA	18	18	6	2,322	8	83.7%
(PRESBYTERIAN HOME OF SC CLINTON)		LAURENS	CLINTON	NPA	(48)	(48)				
LAURENS COUNTY		TOTAL			420	420	686	138,584	410	92.7%
AGAPE NURSING AND REHABILIATION CENTER		LEXINGTON	W.COLUMBIA	PROP	100	100	492	30,800	100	84.4%
BRIAN CENTER NURSING CARE - ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120	134	39,425	120	90.0%
HEARTLAND LEXINGTON REHAB & NURSING CTR		LEXINGTON	W.COLUMBIA	PROP	132	132	293	36,713	132	76.2%
LEXINGTON MEDICAL CENTER EXTENDED CARE		LEXINGTON	LEXINGTON	NPA	388	388	691	134,759	388	95.2%
NHC HEALTHCARE - LEXINGTON		LEXINGTON	W.COLUMBIA	PROP	120	120	313	41,909	120	95.7%
PRESBYTERIAN HOME OF SC COLUMBIA		LEXINGTON	W COLUMBIA	NPA	44	44	33	13,153	44	81.9%
SC EPISCOPAL HOME AT STILL HOPES		LEXINGTON	W.COLUMBIA	NPA	20	20	15	5,952	20	81.5%
(SC EPISCOPAL HOME AT STILL HOPES)		LEXINGTON	W.COLUMBIA	NPA	(42)	(42)				
LEXINGTON COUNTY		TOTAL			924	924	1,971	302,711	924	89.8%
PETRA HEALTH & REHAB MCCORMICK	16	MCCORMICK	MCCORMICK	CO	120	120	127	41,434	120	94.6%
MCCORMICK COUNTY		TOTAL			120	120	127	41,434	120	94.6%
J F HAWKINS NURSING HOME		NEWBERRY	NEWBERRY	CO	118	118	49	41,425	118	96.2%
NEWBERRY CO MEM HOSP - TRANS CARE UNIT		NEWBERRY	NEWBERRY	CO	12	12	163	1,397	12	31.9%
WHITE OAK MANOR - NEWBERRY		NEWBERRY	NEWBERRY	PROP	146	146	84	52,195	146	97.9%
NEWBERRY COUNTY					276	276	296	95,017	276	94.3%
COUNTRYWOOD NURSING CENTER		RICHLAND	HOPKINS	PROP	38	38	28	12,998	38	93.7%
HEARTLAND COLUMBIA REHAB & NURSING CTR	17	RICHLAND	COLUMBIA	PROP	132	132	468	43,371	132	90.0%
HERITAGE AT LOWMAN REHAB & HEALTHCARE	18	RICHLAND	WHITE ROCK	NPA	176	176	187	58,258	176	90.7%
LIFE CARE CENTER OF COLUMBIA		RICHLAND	COLUMBIA	PROP	179	179	491	58,567	179	89.6%
MAGNOLIA MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	88	88	115	29,940	88	93.2%
NHC HEALTHCARE - PARKLANE		RICHLAND	COLUMBIA	PROP	180	180	294	63,321	180	96.4%
OAKS OF BLYTHEWOOD	19	RICHLAND	BLYTHEWOOD	PROP	120	120	0			
PALMETTO HEALTH BAPTIST SUBACUTE REHAB		RICHLAND	COLUMBIA	NPA	22	22	571	5,476	22	68.2%
RICE ESTATE REHAB & HEALTHCARE		RICHLAND	COLUMBIA	NPA	32	32	71	11,227	32	96.1%
UNI-HEALTH POST ACUTE CARE COLUMBIA	19	RICHLAND	COLUMBIA	PROP	171	171	296	65,594	257	69.9%
WHITE OAK MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120	71	43,018	120	98.2%
WILDEWOOD DOWNS NURSING CENTER	20	RICHLAND	COLUMBIA	PROP	72	72	221	11,207	44	69.2%
(WILDEWOOD DOWNS NURSING CENTER)		RICHLAND	COLUMBIA	PROP	(8)	(8)				
(W J B DORN VA)		RICHLAND	COLUMBIA	FED		(94)				
RICHLAND COUNTY		TOTAL			1,330	1,330	2,813	402,977	1,268.4	87.0%
SALUDA NURSING CENTER		SALUDA	SALUDA	CO	176	176	151	61,207	176	95.3%
SALUDA COUNTY		TOTAL			176	176	151	61,207	176	95.3%

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
AGAPE REHABILITATION ROCK HILL		YORK	ROCK HILL	PROP	99	99	389	31,526	99	87.2%
MAGNOLIA MANOR - ROCK HILL		YORK	ROCK HILL	PROP	106	106				
UNI-HEALTH POST ACUTE CARE ROCK HILL		YORK	ROCK HILL	PROP	132	132	252	42,515	132	88.2%
WESTMINSTER HEALTH & REHABILITATION CTR		YORK	ROCK HILL	PROP	66	66	275	21,284	66	88.4%
WHITE OAK MANOR - ROCK HILL		YORK	ROCK HILL	PROP	141	141	71	50,443	141	98.0%
WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109	96	38,713	109	97.3%
WILLOW BROOK COURT		YORK	ROCK HILL	PROP	40	40	116	11,309	40	77.5%
YORK COUNTY		TOTAL			693	693	1,199	195,790	587	91.4%
TOTAL					5,423	5,423	9,551	1,711,942	5,143	91.2%

FOOTNOTES 2010-11 PLAN

REGION II

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1 CON issued 10/12/07 to add 31 general beds for a total of 199 acute and 18 substance abuse beds, SC-07-49. CON approved 8/22/08 to convert 18 substance abuse beds to general beds, for a total of 217 general beds; appealed. Licensed for 199 acute and 18 substance abuse beds 12/30/08.

2 CON issued 9/14/07 for 38 additional acute beds for a total of 384 beds, SC-07-35. License increased to 354 beds 1/29/08. Licensed for 384 beds 6/13/08. CON approved 10/20/09 to add 30 beds for a total of 414; appealed. CON issued 1/21/10, SC-10-6. Licensed for 414 beds 8/25/10.

3 CON approved to construct a new 76 bed hospital (Palmetto Health Parkridge) by transferring 76 beds from Palmetto Health Baptist, resulting in 287 general beds, 104 psych and 22 nursing home beds remaining at Palmetto Health Baptist; appealed. CON issued 6/8/10, SC-10-16.

4 CON approved 9/26/05 to convert 11 nursing home beds at Providence NE to general acute beds and to de-license the other 7 nursing home beds, for a total of 57 acute beds. Project was appealed and subsequently withdrawn 11/06. Exemption issued 3/23/06 to de-license the 18 nursing home beds at Providence Northeast, E-06-13; beds were de-licensed on 5/24/06. CON approved 8/27/07 to add 38 general beds for a total of 84 beds; appealed. SC-09-10 issued 3/3/09 after the appeal was withdrawn. Licensed beds increased from 46 to 56 on 12/3/09.

5 Bed use restricted. Beds reported by facility.

6. CON issued 7/18/06 for the addition of 32 psych beds for a total of 71 psych beds, SC-06-42. CON voided on 4/17/07, but the applicant appealed the Department's decision. After appeal, a new CON was issued 12/14/07, SC-07-65. CON issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psychiatric beds from Palmetto Baptist, for a total of 17 substance abuse and 81 psych beds at Three Rivers, SC-08-05. Licensed for 49 psych beds and 17 substance abuse beds on 7/21/08. Licensed for 81 psych beds 7/10/09.

7. CON issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psychiatric beds from Palmetto Baptist, for a total of 10 substance abuse and 94 psych beds at Palmetto Baptist, SC-08-06. Licensed for 10 substance abuse and 94 psych beds 7/21/08.

8. Licensed for 20 RTF beds 6/16/09; intend to license 30 RTF beds.

9. Facility converted from a High Management Group Home, licensed 11/20/08.

10. CON issued 6/30/09 to add 6 rehab beds for a total of 46, SC-09-32; licensed for 46 beds 7/9/10.

11. CON issued 9/15/06 for a 12-bed inpatient hospice, SC-06-61.

12. Facility de-licensed.

13. CON issued 11/15/07 to add 8 nursing home beds that do not participate in the Medicaid program, for a total of 96 beds, SC-07-58. Licensed for 96 beds 10/1/08.

14. CON issued 1/18/08 to add 44 beds for a total of 192, SC-08-02. CON voided 7/24/09.

15. CON issued 3/12/09 to change the licensure of 18 institutional beds to community beds not participating in the Medicaid program, SC-09-14. Licensed amended 4/23/09.
16. Formerly Savannah Heights Living Center.
17. CON issued 10/15/08 for 2 additional nursing home beds for a total of 134. CON voided 4/13/09.
18. CON approved 2/23/10 to convert 47 beds from institutional to community for a total of 176 community beds. License amended 3/24/10.
19. CON issued 1/29/07 for the construction of a 123 bed nursing home with a Medicaid Nursing Home Permit of 21,900 Medicaid patient days by transferring 89 beds from Carolina Health and Rehab and adding 34 new beds. Carolina Health and Rehab will retain 168 nursing home beds and a Medicaid Nursing Home Permit for 47,100 Medicaid patient days; SC-07-04. Name of Carolina Health and Rehab changed to UniHealth Post-Acute Columbia 6/20/08. CON amended 5/14/08 to reduce the number of beds at the Oaks of Blythewood from 123 to 120, with the number of beds retained at UniHealth Post-Acute Columbia increased from 168 to 171. UniHealth Post-Acute Care – Blythewood licensed for 120 beds 8/20/10; UniHealth Post-Acute Columbia licensed beds decreased to 171 the same day.
20. CON issued 9/11/08 for the addition of 8 institutional beds and 40 general nursing home beds for a total of 80 beds (8 institutional and 72 general), SC-08-35. Licensed for the additional beds on 9/10/09.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS
REGION II:	EMERGENCY FACILITIES	
III	ABBEVILLE CO MEMORIAL HOSPITAL	10,721
II	CHESTER MEDICAL CENTER	17,380
III	EDGEFIELD COUNTY HOSPITAL	5,817
III	FAIRFIELD MEMORIAL HOSPITAL	11,547
II	SELF REGIONAL HEALTH CARE	44,733
III	KERSHAW HEALTH	26,442
II	SPRINGS MEMORIAL HOSPITAL	32,515
II	LAURENS COUNTY HOSPITAL	30,321
II	LEXINGTON MEDICAL CENTER	93,782
III	NEWBERRY CO MEMORIAL HOSPITAL	21,584
II	PALMETTO HEALTH BAPTIST	38,439
I	PALMETTO HEALTH RICHLAND	79,488
II	PROVIDENCE HOSPITAL	19,178
II	PROVIDENCE HOSPITAL NORTHEAST	35,152
II	PIEDMONT MEDICAL CENTER	53,339
		520,438

REGION II:	TRAUMA CENTERS	
III	SELF MEM REGIONAL HEALTH CARE	
III	LEXINGTON MEDICAL CENTER	
I	PALMETTO HEALTH RICHLAND	
III	PIEDMONT MEDICAL CTR	

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: III

FISCAL YEAR: 2009

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." The inland waterway is a barrier to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
CHESTERFIELD GENERAL HOSPITAL		CHESTERFIELD	CHERAW	PROP	59	59	2,765	10,299	59	47.8%
CHESTERFIELD COUNTY		TOTAL			59	59	2,765	10,299	59	47.8%
CLARENDON MEMORIAL HOSPITAL	1	CLARENDON	MANNING	CO	56	81	2,968	13,498	56	66.0%
CLARENDON COUNTY		TOTAL			56	81	2,968	13,498	56	66.0%
CAROLINA PINES REGIONAL MEDICAL CENTER		DARLINGTON	HARTSVILLE	NPA	116	116	7,852	30,057	116	71.0%
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	49	49	505	2,204	49	12.3%
DARLINGTON COUNTY		TOTAL			165	165	8,357	32,261	165	53.6%
MCLEOD MEDICAL CENTER - DILLON		DILLON	DILLON	NPA	79	79	3,092	10,620	79	36.8%
DILLON COUNTY		TOTAL			79	79	3,092	10,620	79	36.8%
CAROLINAS HOSPITAL SYSTEM		FLORENCE	FLORENCE	PROP	310	310	11,425	60,536	310	53.5%
LAKE CITY COMMUNITY HOSPITAL		FLORENCE	LOWER FLOREN(	DIST	48	48	1,648	4,323	48	24.7%
MCLEOD REGIONAL MEDICAL CENTER		FLORENCE	FLORENCE	NPA	453	453	23,022	113,181	453	68.5%
WOMEN'S CENTER CAROLINAS HOSP SYSTEM		FLORENCE	FLORENCE	PROP	20	20	842	3,483	20	47.7%
FLORENCE COUNTY		TOTAL			831	831	36,937	181,523	831	59.8%
GEORGETOWN MEMORIAL HOSPITAL	2	GEORGETOWN	GEORGETOWN	NPA	131	131	6,219	27,489	131	57.3%
WACCAMAW COMMUNITY HOSPITAL		GEORGETOWN	MURRELLS INLET	NPA	124	124	7,224	27,972	87.4	87.4%
GEORGETOWN COUNTY		TOTAL			255	255	13,443	55,461	218.4	69.4%
CONWAY HOSPITAL	3	HORRY	CONWAY	NPA	210	210	9,442	35,770	160	61.3%
GRAND STRAND REGIONAL MEDICAL CENTER	4	HORRY	MYRTLE BEACH	PROP	219	269	13,376	57,593	219	72.0%
LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105	4,053	16,465	105	43.0%
SEACOAST MEDICAL CENTER	5	HORRY	LITTLE RIVER	DIST		50				
HORRY COUNTY		TOTAL			534	634	26,871	109,828	484	62.2%
MARION REGIONAL HOSPITAL		MARION	MARION	DIST	124	124	4,350	17,653	124	39.0%
MARION COUNTY		TOTAL			124	124	4,350	17,653	124	39.0%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	94	94	1,539	4,223	94	12.3%
MARLBORO COUNTY		TOTAL			94	94	1,539	4,223	94	12.3%
TUOMEY		SUMTER	SUMTER	NPA	283	283	8,119	66,720	283	64.6%
SUMTER COUNTY		TOTAL			283	283	8,119	66,720	283	64.6%
WILLIAMSBURG REGIONAL HOSPITAL		WILLIAMSBURG	KINGSTREE	CO	25	25	552	1,493	25	16.4%
WILLIAMSBURG COUNTY		TOTAL			25	25	552	1,493	25	16.4%
TOTAL					**2,505**	**2,630**	**108,993**	**503,579**	**2,418**	**57.0%**
LONG TERM ACUTE HOSPITALS:										
REGENCY HOSPITAL OF SOUTH CAROLINA		FLORENCE	FLORENCE	PROP	40	40	409	11,339	40	77.7%
TOTAL					**40**	**40**	**409**	**11,339**	**40**	**77.7%**
MENTAL FACILITIES:										
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	23	23	612	4,658	23	55.5%
DARLINGTON COUNTY		TOTAL			23	23	612	4,658	23	55.5%
CAROLINAS HOSP SYS - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	257	2,407	12	55.0%
FLORENCE COUNTY		TOTAL			12	12	257	2,407	12	55.0%
LIGHTHOUSE CARE CENTER OF CONWAY	6	HORRY	CONWAY	PROP	44	59	1,040	11,639	44	72.5%
HORRY COUNTY		TOTAL			44	59	1,040	11,639	44	72.5%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	8	8	0	0	8	0.0%
MARLBORO COUNTY		TOTAL			8	8	0	0	8	0.0%
TOTAL					**87**	**102**	**1,909**	**18,704**	**87**	**58.9%**

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO PEE DEE RES TREATMENT CTR		FLORENCE	FLORENCE	PROP	59	59	62	20,489	59	95.1%
LIGHTHOUSE CARE CENTER OF CONWAY	6	HORRY	CONWAY	PROP	30	30	14	5,755	18.4	85.6%
WILLOWGLEN ACADEMY SOUTH CAROLINA	7	WILLIAMSBURG	GREELEYVILLE	PROP	40	54	35	4,933	31.5	43.0%
TOTAL					129	143	111	31,177	109	78.2%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	372	1,931	12	44.1%
LIGHTHOUSE CARE CENTER OF CONWAY	6	HORRY	CONWAY	PROP	8	14	371	2,526	8	86.5%
TOTAL					20	26	743	4,457	20	61.1%
REHABILITATION FACILITIES:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	NPA	42	42	1,387	14,235	42	92.9%
HEALTHSOUTH REHAB HOSPITAL FLORENCE		FLORENCE	FLORENCE	PROP	88	88	1,180	18,149	88	56.5%
FLORENCE COUNTY		TOTAL			130	130	2,567	32,384	130	68.2%
WACCAMAW COMMUNITY HOSPITAL		GEORGETOWN	MURRELLS INLET	NPA	43	43	1,037	12,839	43	81.8%
GEORGETOWN COUNTY		TOTAL			43	43	1,037	12,839	43	81.8%
TOTAL					173	173	3,604	45,223	173	71.6%
INPATIENT HOSPICE FACILITIES:										
MCLEOD HOSPICE HOUSE	8	FLORENCE	FLORENCE	NPA	12	24	469	3,708	12	84.7%
TIDELANDS COMMUNITY HOSPICE HOUSE		GEORGETOWN	GEORGETOWN	NPA	12	12	206	1,763	12	40.3%
(AGAPE HOSPICE HOUSE OF HORRY COUNTY)	9	HORRY	CONWAY	PROP	(24)	(24)	0	0		
TOTAL					24	36	675	5,471	24	62.5%
LONG TERM FACILITIES:										
CHERAW HEALTHCARE	10	CHESTERFIELD	CHERAW	PROP	120	120	68	42,563	117.6	99.2%
CHESTERFIELD CONVALESCENT CENTER		CHESTERFIELD	CHERAW	PROP	104	104	43	36,620	104	96.5%
CHESTERFIELD COUNTY		TOTAL			224	224	111	79,183	222	97.9%
LAKE MARION NURSING FACILITY		CLARENDON	SUMMERTON	PROP	88	88	55	30,317	88	94.4%
WINDSOR MANOR		CLARENDON	MANNING	PROP	64	64	15	22,630	64	96.9%
CLARENDON COUNTY		TOTAL			152	152	70	52,947	152	95.4%
BETHEA BAPTIST HEALTH CARE CENTER		DARLINGTON	DARLINGTON	NPA	36	36	30	11,591	36	88.2%
(BETHEA BAPTIST HEALTH CARE CENTER)		DARLINGTON	DARLINGTON	NPA	(52)	(52)				
MEDFORD NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	38	30,828	88	96.0%
MORRELL NURSING CENTER		DARLINGTON	HARTSVILLE	PROP	154	154	283	50,856	154	90.5%
OAKHAVEN NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	41	31,185	88	97.1%
DARLINGTON COUNTY		TOTAL			366	366	392	124,460	366	93.2%
HERITAGE HEALTHCARE AT THE PINES		DILLON	DILLON	PROP	84	84	72	30,101	84	98.2%
SUNNY ACRES		DILLON	FORK	PROP	111	111	47	38,922	111	96.1%
DILLON COUNTY		TOTAL			195	195	119	69,023	195	97.0%
CAROLINAS HOSP SYS TRANS CARE UNIT		FLORENCE	FLORENCE	PROP	24	24	415	5,532	24	63.2%
COMMANDER NURSING CENTER		FLORENCE	FLORENCE	PROP	163	163	97	58,045	163	97.6%
FAITH HEALTHCARE CENTER		FLORENCE	FLORENCE	PROP	104	104	80	35,900	104	94.6%
FLORENCE REHAB & NURSING CENTER	11	FLORENCE	FLORENCE	PROP	88	88	84	29,329	88	91.3%

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132	90	47,391	132	98.4%
HONORAGE NURSING CENTER		FLORENCE	FLORENCE	PROP	88	88	60	31,399	88	97.8%
LAKE CITY - SCRANTON HEALTH CARE CTR		FLORENCE	SCRANTON	PROP	88	88	198	31,092	88	96.8%
SOUTHLAND HEALTH CARE CENTER		FLORENCE	FLORENCE	PROP	88	88	48	31,258	88	97.3%
FLORENCE COUNTY		TOTAL			775	775	1,072	269,946	775	95.4%
GEORGETOWN HEALTH AND REHAB		GEORGETOWN	GEORGETOWN	PROP	84	84	39	26,624	84	86.8%
LAKES AT LITCHFIELD SKILLED NURS CTR		GEORGETOWN	PAWLEYS ISLANI	PROP	17	17	153	4,955	17	79.6%
(LAKES AT LITCHFIELD SKILLED NURS CTR)		(GEORGETOWN)	(PAWLEYS ISLAN	(PROP)	(7)	(7)	63			
PRINCE GEORGE HEALTHCARE CENTER		GEORGETOWN	GEORGETOWN	PROP	148	148				
GEORGETOWN COUNTY		TOTAL			249	249	255	31,579	101	85.7%
AGAPE REHABILITATION CTR CONWAY	12	HORRY	CONWAY	PROP	72	96	83	2,512	39.3	17.5%
BRIGHTWATER SKILLED NURSING CENTER	13	HORRY	MYRTLE BEACH	PROP	32	32	10	1,465	23.1	17.3%
CONWAY MANOR		HORRY	CONWAY	PROP	190	190	211	64,812	190	93.5%
COVENANT TOWERS HEALTH CARE		HORRY	MYRTLE BEACH	PROP	30	30	230	8,101	30	74.0%
GRAND STRAND HEALTH CARE		HORRY	CONWAY	PROP	88	88	102	30,825	88	96.0%
KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88	296	30,501	88	95.0%
LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88	216	29,483	88	91.8%
MYRTLE BEACH MANOR	14	HORRY	MYRTLE BEACH	PROP	100	100	341	30,072	104	79.2%
NHC HEALTHCARE - GARDEN CITY		HORRY	MYRTLE BEACH	PROP	148	148	434	48,862	148	90.5%
SEASIDE LIVING CENTER	15	HORRY	MYRTLE BEACH	PROP	0	60				
SHEPHERD'S LANDING NURSING & REHAB CTR	16	HORRY	LITTLE RIVER	PROP	0	60				
HORRY COUNTY		TOTAL			836	980	1,923	246,633	798.4	84.6%
MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120	139	41,289	120	94.3%
LEE COUNTY		TOTAL			120	120	139	41,289	120	94.3%
MARION NURSING CENTER		MARION	MARION	PROP	88	88	40	30,922	88	96.3%
MULLINS NURSING CENTER		MARION	MARION	NPA	92	92	35	33,157	92	98.7%
MARION COUNTY		TOTAL			180	180	75	64,079	180	97.5%
DUNDEE MANOR		MARLBORO	BENNETTSVILLE	PROP	110	110	84	38,005	110	94.7%
MARLBORO COUNTY		TOTAL			110	110	84	38,005	110	94.7%
HOPEWELL HEALTH CARE CENTER		SUMTER	SUMTER	PROP	96	96	39	33,312	96	95.1%
NHC HEALTHCARE - SUMTER		SUMTER	SUMTER	PROP	138	138	95	48,440	138	96.2%
SUMTER EAST HEALTH & REHAB CENTER		SUMTER	SUMTER	PROP	176	176	188	62,963	176	98.0%
TUOMEY SUBACUTE SKILLED CARE		SUMTER	SUMTER	NPA	18	18	476	5,171	18	78.7%
SUMTER COUNTY		TOTAL			428	428	798	149,886	428	95.7%
DR. RONALD E. MCNAIR NURSING & REHAB		WILLIAMSBURG	CADES	PROP	88	88	59	27,135	88	84.5%
KINGSTREE NURSING FACILITY		WILLIAMSBURG	KINGSTREE	PROP	96	96	63	31,235	96	89.1%
WILLIAMSBURG COUNTY		TOTAL			184	184	122	58,370	184	86.7%
TOTAL					3,819	3,963	5,160	1,225,400	3,631	92.5%

FOOTNOTES 2010-11 PLAN

REGION III

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 10/27/08 to add 25 beds for a total of 88 beds, SC-08-44.
2. CON issued 3/2/09 to construct a replacement of the existing hospital, with a decrease in bed capacity from 131 to 129 beds, SC-09-09.
3. CON issued 2/1/06 to add 50 general beds for a total of 210 general beds, SC-06-04. Licensed for 210 beds 7/16/09.
4. CON approved 9/4/07 to add 50 general acute beds for a total of 269.
5. CON approved 8/29/05 to establish a hospital with 50 general acute beds; appealed. CON issued per ALJ Order 9/28/07, SC-07-47.
6. Number of licensed RTF beds increased from 16 to 30 10/29/09. CON approved to add 15 psych beds, for a total of 59, and 6 inpatient substance abuse beds, for a total of 14; appealed. Appeal withdrawn, CON SC-10-07 issued 1/25/10.
7. Converted 40 beds from a High Maintenance Group Home to Residential Treatment Facility beds on 3/20/09; intend to license 54 RTF beds.
8. CON approved to add 12 beds for a total of 24, 2/23/10.
9. CON issued 3/5/07 for a 24-bed inpatient hospice, SC-07-08. Licensed 3/31/09. CON issued 7/15/10 to convert the 24 inpatient hospice beds to nursing home beds for a total of 96 nursing home beds, SC-10-21.
10. CON approved 6/26/07 to construct a replacement facility and add 17 beds that do not participate in the Medicaid program for a 117 bed nursing home. New facility licensed for 117 beds 5/1/08. CON issued 4/16/09 to add 3 beds for a total of 120, SC-09-17. Licensed for 120 beds 7/24/09.
11. Formerly Cooke Associates of Florence.
12. CON issued 3/5/07 for a 72-bed nursing home that does not participate in the Medicaid program/ SC-07-07. Facility licensed 3/18/09. CON issued 7/15/10 to convert the 24 inpatient hospice beds to nursing home beds for a total of 96 nursing home beds, SC-10-21.
13. CON issued 5/9/08 for a 32-bed nursing home that does not participate in the Medicaid program, SC-08-15. Licensed 4/13/09.
14. De-licensed 4 nursing home beds for a total of 100 beds, 2/22/10.
15. CON issued 10/14/10 for a 60 bed nursing home that does not participate in the Medicaid program, SC-10-30.
16. CON issued 3/12/09 for a 60 bed nursing home that does not participate in the Medicaid program, SC-09-12.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS
REGION III:	EMERGENCY FACILITIES	
II	CHESTERFIELD GENERAL HOSPITAL	13,336
III	CLARENDON MEMORIAL HOSPITAL	18,068
III	CAROLINA PINES REGIONAL MED CTR	32,627
III	MCLEOD - DILLON	25,419
III	CAROLINAS HOSPITAL SYSTEM	36,346
II	MCLEOD REGIONAL MED CENTER	60,247
III	LAKE CITY COMMUNITY HOSPITAL	15,296
II	GEORGETOWN MEMORIAL HOSPITAL	31,990
II	WACCAMAW COMMUNITY HOSPITAL	26,252
II	CONWAY HOSPITAL	43,813
III	LORIS COMMUNITY HOSPITAL	41,227
II	GRAND STRAND REGIONAL MED CTR	67,167
III	MARION REGIONAL HOSPITAL	23,275
III	MARLBORO PARK HOSPITAL	14,971
II	TUOMEY	54,755
III	WILLIAMSBURG REGIONAL	11,027
		515,816

REGION III:	TRAUMA CENTERS
III	CAROLINA PINES REGIONAL MED CTR
III	CAROLINAS HOSPITAL SYSTEM
III	MCLEOD REGIONAL MED CENTER
III	CONWAY HOSPITAL
III	LORIS COMMUNITY HOSPITAL
III	GRAND STRAND REGIONAL MED CTR

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: IV FISCAL YEAR: 2009

1. Unusual Characteristics: This region has a military presence in Charleston. A naval hospital provides health care services for the active duty and dependents residing in this region. A 376 bed Veterans Administration Hospital is located in Charleston. The only medical university hospital in the State is located in Charleston. The Marine Air Base and Parris Island Marine Base are located near Beaufort with naval hospital to provide care to the active duty and dependents. The sea islands, rivers and sounds are barriers to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	183	183	8,753	40,277	183	60.3%
AIKEN COUNTY		TOTAL			183	183	8,753	40,277	183	60.3%
ALLENDALE COUNTY HOSPITAL		ALLENDALE	FAIRFAX	CO	25	25	297	1,237	25	13.6%
ALLENDALE COUNTY HOSPITAL		TOTAL			25	25	297	1,237	25	13.6%
BAMBERG COUNTY MEMORIAL	1	BAMBERG	BAMBERG	CO	59	59	968	3,054	59	14.2%
BAMBERG COUNTY		TOTAL			59	59	968	3,054	59	14.2%
BARNWELL COUNTY HOSPITAL		BARNWELL	BARNWELL	CO	53	53	817	2,392	53	12.4%
BARNWELL COUNTY		TOTAL			53	53	817	2,392	53	12.4%
BEAUFORT COUNTY MEMORIAL		BEAUFORT	BEAUFORT	CO	169	169	9,825	40,413	169	65.5%
HILTON HEAD HOSPITAL		BEAUFORT	HILTON HEAD	NPA	93	93	4,948	19,064	93	56.2%
NAVAL HOSPITAL	2	BEAUFORT	BEAUFORT	FED		(64)				
BEAUFORT COUNTY		TOTAL			262	262	14,773	59,477	262	62.2%
BERKELEY MEDICAL CENTER	3	BERKELEY	MONCKS CORNE	PROP		50				
ROPER ST FRANCIS HOSPITAL - BERKELEY	4	BERKELEY	GOOSE CREEK	NPA		50				
BERKELEY COUNTY		TOTAL			0	100				
BON-SECOURS ST. FRANCIS XAVIER		CHARLESTON	CHARLESTON	NPA	204	204	8,661	35,376	204	47.5%
EAST COOPER MEDICAL CENTER	5	CHARLESTON	MT PLEASANT	PROP	130	130	4,980	16,966	100	46.5%
MEDICAL UNIVERSITY HOSPITAL	6	CHARLESTON	CHARLESTON	ST	604	604	27,654	146,361	584	68.7%
ROPER HOSPITAL	4	CHARLESTON	CHARLESTON	NPA	316	266	15,473	80,393	401	54.9%
ROPER ST. FRANCIS MOUNT PLEASANT HOSPITAL	4	CHARLESTON	MT PLEASANT	NPA	85	85				
TRIDENT MEDICAL CENTER		CHARLESTON	CHARLESTON	PROP	296	296	15,536	71,117	296	65.8%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(144)				
CHARLESTON COUNTY		TOTAL			1,635	1,585	72,304	350,213	1,585	60.5%
COLLETON MEDICAL CENTER		COLLETON	WALTERBORO	PROP	131	131	4,104	22,841	131	47.8%
COLLETON COUNTY		TOTAL			131	131	4,104	22,841	131	47.8%
SUMMERVILLE MEDICAL CENTER		DORCHESTER	SUMMERVILLE	PROP	94	94	5,564	20,787	94	60.6%
DORCHESTER COUNTY		TOTAL			94	94	5,564	20,787	94	60.6%
HAMPTON REGIONAL MEDICAL CENTER		HAMPTON	VARNVILLE	CO	32	32	891	3,722	32	31.9%
HAMPTON COUNTY		TOTAL			32	32	891	3,722	32	31.9%
COASTAL CAROLINA MEDICAL CENTER		JASPER	HARDEEVILLE	PROP	31	31	1,035	3,799	31	33.6%
JASPER COUNTY		TOTAL			31	31	1,035	3,799	31	33.6%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	247	247	11,139	51,863	247	57.5%
ORANGEBURG COUNTY		TOTAL			247	247	11,139	51,863	247	57.5%
TOTAL					2,752	2,802	120,645	559,662	2,702	56.7%
LONG TERM ACUTE HOSPITALS:										
KINDRED HOSPITAL - CHARLESTON		CHARLESTON	CHARLESTON	PROP	59	59	264	9,901	59	46.0%
TOTAL					59	59	264	9,901	59	46.0%
MENTAL FACILITIES:										
AIKEN REGIONAL MEDICAL CENTER	7	AIKEN	AIKEN	PROP	29	41	1,189	10,498	29	99.2%
AIKEN COUNTY		TOTAL			29	41	1,189	10,498	29	99.2%
BEACON HARBOR GERIATRIC PSYCHIATRIC CARE	8	BEAUFORT	BLUFFTON	PROP	0	22				
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	364	2,492	14	48.8%
BEAUFORT COUNTY		TOTAL			14	36	364	2,492	14	48.8%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82	2,368	19,026	82	63.6%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	CHARLESTON	PROP	70	70	892	16,015	70	62.7%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(36)				
CHARLESTON COUNTY		TOTAL			152	152	3,260	35,041	152	63.2%

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15		2,704	15	49.4%
ORANGEBURG COUNTY		TOTAL			15	15	0	2,704	15	49.4%
TOTAL					**210**	**244**	**4,813**	**50,735**	**210**	**66.2%**
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO LOWCOUNTY BEHAV. HEALTH RTC		CHARLESTON	CHARLESTON	PROP	32	32	58	11,059	32	94.7%
RIVERSIDE BEHAVIORAL AT WINDWOOD FARM	9	CHARLESTON	AWENDAW	PROP	12	12				
PALMETTO PINES BEHAVIORAL HEALTH		SUMMERVILLE	DORCHESTER	PROP	60	60	45	20,156	60	92.0%
PINELANDS RESIDENTIAL TREATMENT CENTER	10	SUMMERVILLE	DORCHESTER	PROP	14	28				
TOTAL					**118**	**132**	**103**	**31,215**	**92**	**92.7%**
DRUG AND ALCOHOL INPATIENT TREATMENT:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	18	18	596	4,121	18	62.7%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10	568	4,275	10	117.1%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	23	23	590	3,329	23	39.7%
TOTAL					**51**	**51**	**1,754**	**11,725**	**51**	**63.0%**
REHABILITATION FACILITIES:										
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	265	2,978	14	58.3%
BEAUFORT COUNTY		TOTAL			14	14	265	2,978	14	58.3%
ROPER HOSPITAL	11	CHARLESTON	CHARLESTON	NPA	52	52	850	11,422	41.3	75.8%
HEALTHSOUTH CHARLESTON		CHARLESTON	CHARLESTON	PROP	46	46	981	12,894	46	76.8%
CHARLESTON COUNTY		TOTAL			98	98	1,831	24,316	87.3	76.3%
COASTAL CAROLINA MEDICAL CENTER		JASPER	HARDEEVILLE	PROP	10	10	128	761	10	20.8%
JASPER COUNTY		TOTAL			10	10	128	761	10	20.8%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	24	24		6,174	24	70.5%
ORANGEBURG COUNTY		TOTAL			24	24	0	6,174	24	70.5%
TOTAL					**146**	**146**	**2,224**	**34,229**	**135**	**69.3%**
INPATIENT HOSPICE FACILITIES:										
THE HOSPICE OF CHARLESTON		CHARLESTON	CHARLESTON	NPA	20	20	517	4,935	20	67.6%
TOTAL					**20**	**20**	**517**	**4,935**	**20**	**67.6%**
LONG TERM FACILITIES:										
AZALEA WOODS REHAB & NURSING CENTER		AIKEN	AIKEN	PROP	86	86	44	30,036	86	95.7%
FAITH HEALTH & REHAB AIKEN	12	AIKEN	AIKEN	PROP	60	60	531	20,706	60	94.5%
NHC HEALTHCARE N. AUGUSTA		AIKEN	N. AUGUSTA	PROP	192	192	315	58,042	192	82.6%
PEPPER HILL NURSING CENTER		AIKEN	AIKEN	PROP	132	132	164	45,519	132	94.5%
UNIHEALTH POST-ACUTE - AIKEN	13	AIKEN	AIKEN	PROP	176	176	322	60,294	176	93.6%
UNIHEALTH POST-ACUTE - NORTH AUGUSTA		AIKEN	N. AUGUSTA	PROP	132	132				
AIKEN COUNTY		TOTAL			778	778	1,376	214,597	646	91.0%
JOHN E HARTER NURSING HOME		ALLENDALE	FAIRFAX	CO	44	44	20	13,893	44	86.3%
ALLENDALE COUNTY		TOTAL			44	44	20	13,893	44	86.3%
UNIHEALTH POST-ACUTE CARE BAMBERG		BAMBERG	BAMBERG	CO	88	88	34	12,559	88	39.0%
BAMBERG COUNTY		TOTAL			88	88	34	12,559	88	39.0%
LAUREL BAYE HEALTHCARE OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	30	29,168	85	94.0%
LAUREL BAYE HEALTHCARE OF WILLISTON		BARNWELL	WILLISTON	PROP	44	44	85	15,529	44	96.7%
UNIHEALTH POST-ACUTE BARNWELL	14	BARNWELL	BARNWELL	CO	44	44	82	16,143	44	100.5%
BARNWELL COUNTY		TOTAL			173	173	197	60,840	173	96.3%

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2009**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
BAYVIEW MANOR		BEAUFORT	BEAUFORT	PROP	170	170	228	54,749	170	88.2%
BEACON HARBOR SUBACUTE CARE	15	BEAUFORT	BLUFTON	PROP	0	120				
BROAD CREEK CARE CENTER		BEAUFORT	HILTON HEAD	PROP	25	25	158	8,849	25	97.0%
LIFE CARE CENTER OF HILTON HEAD		BEAUFORT	HILTON HEAD	PROP	88	88	242	26,807	88	83.5%
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	19	19	69	5,368	19	77.4%
(FRASER HEALTH CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				
NHC BLUFFTON	16	BEAUFORT	BLUFTON	PROP	0	120	0			
PRESTON HEALTH CARE CENTER		BEAUFORT	HILTON HEAD	PROP	69	69	135	15,404	69	61.2%
(PRESTON HEALTH CARE CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)	15			
BEAUFORT COUNTY		TOTAL			371	611	847	111,177	371	82.1%
HEARTLAND HEALTH CARE CTR - CHARLESTON	17	BERKELEY	HANAHAN	PROP	105	135	454	34,213	105	89.3%
LAKE MOULTRIE NURSING HOME		BERKELEY	ST STEPHENS	PROP	88	88	56	30,844	88	96.0%
UNIHEALTH POST-ACUTE MONCKS CORNER		BERKELEY	MONCKS CORNE	PROP	132	132				
BERKELEY COUNTY		TOTAL			325	355	510	65,057	193	92.4%
CALHOUN CONVALESCENT CENTER		CALHOUN	ST. MATTHEWS	PROP	120	120	85	42,096	120	96.1%
CALHOUN COUNTY		TOTAL			120	120	85	42,096	120	96.1%
BISHOP GADSDEN EPISCOPAL HOME		CHARLESTON	CHARLESTON	NPA	41	41	73	13,001	41	86.6%
(BISHOP GADSDEN EPISCOPAL HOME)		CHARLESTON	CHARLESTON	NPA	(9)	(9)				
DRIFTWOOD REHAB. & NURSING CENTER		CHARLESTON	CHARLESTON	PROP	160	160	162	54,773	160	93.5%
FRANKE HEALTH CARE CENTER		CHARLESTON	CHARLESTON	NPA	24	24	84	7,946	24	90.5%
(FRANKE HEALTH CARE CENTER)		CHARLESTON	CHARLESTON	NPA	(20)	(20)				
GRACE HALL - REHABILITATION		CHARLESTON	MT. PLEASANT	PROP	42	42	25	12,295	42	80.0%
HARVEST HEALTH & REHAB JOHNS ISLAND	18	CHARLESTON	CHARLESTON	NPA	132	132	200	11,812	132	24.4%
HEARTLAND WEST ASHLEY REHAB & NURSING CTR	19	CHARLESTON	CHARLESTON	NPA	99	125	560	33,720	99	93.3%
LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148	586	52,069	148	96.4%
MOUNT PLEASANT MANOR		CHARLESTON	MT. PLEASANT	PROP	132	132	162	46,039	132	95.6%
NATIONAL HEALTH CARE CHARLESTON		CHARLESTON	CHARLESTON	PROP	132	132	457	21,256	132	44.1%
SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176	317	62,041	176	96.6%
WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176	212	59,947	176	93.3%
CHARLESTON COUNTY		TOTAL			1,262	1,288	2,838	374,899	1,262	81.4%
HERITAGE HEALTHCARE OF THE LOWCOUNTRY		COLLETON	WALTERBORO	PROP	132	132	225	48,635	132	100.9%
COLLETON COUNTY		TOTAL			132	132	225	48,635	132	100.9%
HALLMARK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	170	30,969	88	96.2%
OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	133	32,238	88	100.1%
PRESBYTERIAN HOME SUMMERVILLE		DORCHESTER	SUMMERVILLE	NPA	87	87	125	28,638	87	90.2%
ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88				
DORCHESTER COUNTY		TOTAL			351	351	428	91,845	263	95.7%
UNI-HEALTH POST ACUTE CARE - LOWCOUNTRY		HAMPTON	ESTILL	CO	104	104	169	34,284	104	90.3%
HAMPTON COUNTY		TOTAL			104	104	169	34,284	104	90.3%
RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88	64	29,887	88	93.0%
JASPER COUNTY		TOTAL			88	88	64	29,887	88	93.0%
LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113	252	37,441	113	90.8%
JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60	95	21,064	60	96.2%
UNIHEALTH POST-ACUTE CARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	88	88	81	23,049	88	71.8%
THE METHODIST OAKS		ORANGEBURG	ORANGEBURG	NPA	132	132	258	39,503	132	82.0%
ORANGEBURG COUNTY		TOTAL			393	393	686	121,057	393	84.4%
TOTAL					**4,229**	**4,525**	**7,479**	**1,220,826**	**3,877**	**86.3%**

FOOTNOTES 2010-11 PLAN

REGION IV

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON approved 10/24/06 to construct a replacement hospital; appealed. CON issued after ALJ Order to Dismiss 9/14/07, SC-07-36. CON voided 9/3/10.
2. Bed use restricted.
3. CON approved 6/26/09 to construct a new 50 bed hospital in Berkeley County using the bed need generated by Trident Medical Center. Appealed.
4. CON issued 5/31/06 to construct a new hospital in Mount Pleasant by transferring 85 acute beds from Roper Hospital, SC-06-27, leaving a total of 316 beds at Roper Hospital. The approval required that the applicant not commence construction on the project until 2 years from the date of issuance of the CON. CON approved 6/26/09 to construct a new 50 bed hospital (Roper St. Francis Hospital – Berkeley) by transferring 50 existing beds from Roper Hospital, leaving 266 beds at Roper Hospital. Project was appealed. Mount Pleasant Hospital licensed for 85 beds on 11/1/10 and Roper Hospital licensed for 316 beds the same day.

5 CON issued 5/31/06 to construct a replacement hospital with 40 additional beds for a total of 140 acute beds, SC-06-26. Facility reduced the number of additional beds at the replacement hospital from 40 to 30 on 2/27/09, for a total of 130 beds. Licensed for 129 beds 3/17/10. Licensed for 130 beds 6/18/10.

6 CON issued to replace and consolidate Charleston Memorial with Medical University by adding 138 beds (98 from Charleston Memorial, 15 from psych beds, 25 from conversion of rehab beds) for a total of 604 general beds 82 psych & 23 D&A beds, SC-03-60 10/14/03. On 1/30/08, 78 general and 15 psych beds were transferred from Charleston Memorial to MUSC and the 25 rehab beds at MUSC were converted to general acute beds. Charleston Memorial was licensed for 20 acute care beds; MUSC was licensed for 584 acute care beds, 82 psych beds, and 23 substance abuse beds. Charleston Memorial de-licensed 11/25/08. MUSC licensed for 604 acute care beds 9/9/10.

7 CON issued 8/12/10 for the addition of 12 psych beds for a total of 41, SC-10-25.

8 CON issued 8/13/10 to construct a 22 bed psychiatric hospital, SC-10-27.

9 Converted from a High Maintenance Group Home to an RTF 3/18/10.

10 Licensed as a 14 bed RTF 7/21/10; intend to license 28 RTF beds.

11. CON approved 10/16/07 to add 13 rehabilitation beds at Roper for a total of 52; appealed. Case dismissed by ALJ Order 8/29/08. Licensed for 52 rehab beds 10/28/09.
12. Formerly Carriage Hills Living Center.
13. Formerly Heritage at Mattie C. Hall.
14. CON issued 9/16/09 to add 16 beds for a total of 60, SC-09-43. CON voided 3/17/10. Formerly Barnwell County Nursing Home.
15. CON issued 5/7/10 to construct a 120 bed nursing home that does not participate in the Medicaid program, SC-10-15.
16. CON issued 3/28/07 to construct a 120 bed nursing home that does not participate in the Medicaid program, SC-07-11. Licensed 1/21/10.

17. CON issued 10/15/08 for 30 additional nursing home beds for a total of 135, SC-08-40.
18. Formerly Island Oaks Living Center.
19. CON issued 6/15/09 to add 26 nursing home beds for a total of 125 beds, SC-09-30.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2009 ER VISITS
REGION IV:	EMERGENCY FACILITIES	
II	AIKEN REGIONAL MEDICAL CTR	56,082
IV	ALLENDALE COUNTY HOSPITAL	8,083
III	BAMBERG CO MEMORIAL HOSPITAL	11,309
III	BARNWELL COUNTY HOSPITAL	12,675
III	BEAUFORT CO MEMORIAL HOSPITAL	39,462
II	HILTON HEAD HOSPITAL	22,171
II	BON SECOURS ST FRANCIS XAVIER	41,634
II	EAST COOPER MEDICAL CENTER	19,028
(*)	MUSC MEDICAL CENTER	72,512
II	ROPER HOSPITAL	73,489
II	TRIDENT MEDICAL CENTER	61,966
III	COLLETON MEDICAL CENTER	22,908
II	SUMMERVILLE MEDICAL CENTER	40,919
III	HAMPTON REGIONAL MEDICAL CENTER	11,955
III	COASTAL CAROLINA MEDICAL CENTER	14,366
II	REG MED CTR ORANGEBURG-CALHOUN	53,480
		562,039

(*) Met insufficient criteria to be classified.

REGION IV:	TRAUMA CENTERS
III	BEAUFORT CO MEMORIAL HOSPITAL
I	MUSC MEDICAL CENTER
III	ROPER HOSPITAL
III	BON SECOURS ST FRANCIS XAVIER
III	TRIDENT MEDICAL CENTER
III	REG MED CTR ORANGEBURG-CALHOUN